STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675789	A. Building B. Wing	02/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Wood	8810 Long Point Dr 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561 Based on observation, interview, and record review, the facility failed to ensure each resident was free from neglect for one (Resident #1) of eight residents whose records were reviewed for abuse and neglect. The facility failed to supervise Resident #3 and Resident #2, which ended in an unwitnessed resident to resident altercation. Resident #3 was struck on the head with a trashcan and sustained a laceration and hematoma to the forehead which required a hospital visit. On 02/14/24 at 10:45 am an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 02/17/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not an Immediate Jeopardy, due to the facility continuing to monitor the implementation and effectiveness their Plan of Removal. This failure affected 2 residents and could place 13 residents who require supervision inside the memory care unit at risk for abuse, neglect, and a decreased quality of life. Findings included: Resident #2 Record Review of Resident #2's face sheet revealed an eighty-four-year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), generalized anxiety disorder, and hyperlipidemia (high cholesterol). Record review of Resident #2's care plan (completed 7/20/23, revised 01/15/24) revealed that he was incontinent, had a communication problem, had acute/chronic pain, and was a wanderer and elopement risk. No focus areas specified anything regarding resident behaviors. Record review of Resident #2's progress notes revealed the following: (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	07/26/23: Resident roommate is in dining room eating dinner. And Resident #2 is sitting on roommate bed eating his dinner. Writer explains to resident that's not his bed. Resident #2 states fuck this shit, I can stay in this bed, you can't tell me what the fuck to do! Staff redirects resident, but resident still refuses to go his own bed. Resident #2 states This is my place and all these beds is mine! Writer notifies Administrator of Resident #2 non-compliance to go his own bed. And Resident #2 is getting agitated with staff. Roommate moved to other room due to roommate Resident #2s refusal to go to his own bed. 09/04/23: Resident in Room and resident very territorial about his room. Even if resident just comes to his doorway. Resident begins to curse stating quotation I don't want any of you bitches coming in my room!. Staff has to redirect resident. Resident states to staff I'm going to kick all you mother fuckers ass!. Staff has to redirect resident. Staff was trying to pick up resident dinner tray from his room. And resident refused to allow staff in room. Resident sat stuff on floor in room, blocking staff from trying to pick up his finished dinner tray in room. Staff again redirected resident. Resident remained verbally combative towards staff. Staff will continue to redirect and monitor. 9/14/23: Staff has to redirect resident. Resident forgets what side room is on. Resident denies he lives here; staff again redirect their resident. Resident verbally combative towards staff and using profane language too; staff will continue to redirect and monitor. 10/04/23: Resident stayed in his room asleep all through the night. Earlier during change of shift walking rounds, observed resident blocked his door with bedside table and by opening the rest room door, puts a sling on the door making it difficult to open. He mentioned that he don't like other residents wandering into his room and that's why he wants the door closed. Staff encouraged resident not to put ant thing that will make it difficulty in opening the door for his own safety as well, staff will keep an eye on other residents as to not wander into his room and if by any chance, any resident wanders into his room, to use his call button to call on staff who will assist in getting unwelcomed resident out of his room of which he agreed to. 10/27/23: Other male resident from other room on station D wandered into room A. Resident #2 yelling at the resident to get out of his room. Staff intervenes to get other resident out of room. When resident #2 picks-up a plastic hanger and starts swinging the hanger towards the staff members only yelling you bitches get the fuck out my room! Writer explains to resident #2 of trying to get other resident out of his room, please be patient. Writer and staff continue to attempt to remove other resident from room. And resident #2 continues to swing plastic hanger toward staff members only referring to staff members as Bitches, Ugly [NAME]! Finally staff able to remove other resident from room and transfer back to their room. Resident #2 didn't exhibit any physical aggression of swinging hanger toward resident; physical aggression of swinging plastic hanger directed only towards staff members; will continue to monitor. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	11/03/23: Staff reports that resident is much calmer but at a time has exhibited threatening behavior including cursing and swinging plastic hangers at staff during intervention with another resident. Met With resident who is alert, able to let staff know of his needs, talking in a very long time, requires assistance and cuing with ADL and encouragement to take his meds. Educated him to refrain from threatening with an object and he doesn't recall any verbal or physical behavior and sits in day area and participates in activities when encouraged. He is under the services of HCGP, message left related to his behavior and referral for further evaluation and treatment. Resident is under psych/ nurse practitioner care for medication and referral to senior psychology for psychological services and to manage plan. Resident to remain in memory care due to wandering risk, full code and LTC. No DC plan. Staff to approach in a calm and non-threatening monitor and redirect as needed. 11/15/23: resident refuses to take shower according to CNA. Resident frequently urinates on the floor in his room period no other behaviors noted. 11/17/23: resident refused to take shower/bath. Writer explained the importance of bathing but residents still refused. 11/20/23: resident refused morning medication despite writer explaining importance of them. Has tendency to spit out medication after putting them in his mouth. Resident currently in his room will continue to monitor. 01/14/24: staff report that Resident #2 was involved in a physical altercation with another resident and placed under behavioral and safety monitoring. The resident has a long history of mental disorders including paranoid schizophrenia and mood disorder but med intervention in progress. Due to his current behavior, he may need further evaluation for placing self and others in danger. Social workers spoke to behavioral staff to assess for possible inpatient eval and treatment for current signs of mental illness. Behavioral hospital accepted him for care. Nursing notified as accepting psychiatrist, accepting administrator to get transportation and transfer resident to behavioral hospital. Record review of the facility's self-reported incidents in the last 30 days revealed: 01/07/24 at 2pm: Resident #2 and another resident were tugging back and forth over piece of clothing that came from Resident #2's room, when Resident #2 stumbled backwards and hit his head on the door. Resident was admitted to the hospital with traumatic brain injury assault with brain bleed called subdural hemorrhage (bleeding between the brain and the skull) and subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane). 01/14/23 at 8:50 am: Upon investigation, it was discovered that there was blood leading from Resident #2's room where Resident #3 was found lying down. There was blood in Resident #2's room as well as on the side and bottom of his trash can. Resident #3 does wander into other rooms from time to time and Resident #2 does not want anyone in his room. Resident #3 was found in another room laying down on the floor bleeding and was struck in the face. Laceration (deep cut or tear in skin) to forehead with indentation and hematoma (injury where blood collects and pool under skin), swollen nose with discoloration, skin tear to left cheek, and right foot great toe skin tear. No fractures reported by hospital. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 01/26/24 at 10:48 am, Unit Manager stated that since she was promoted into the Unit Manager in November 2023, Resident #2 refused care and was sometimes aggressive with staff, but he was doing well before his most recently reported incident on 01/14/24. Resident #2 was mild mannered and could sometimes be easy to redirect. The unit manager was not aware if Resident #2 had any behavioral ticks and stated that he was in a room without a roommate by chance and not for any specific reason. In an interview on 01/26/24 at 10:53 am, the Unit Manager stated that the facility staff did care plan meetings everyday where they discuss the needs of different residents with the social worker, nurse, and therapist if they were in therapy. The Unit Manager explained that she was responsible for making acute (day to day changes/trends) to the care plan, while each dept head had their own sections for updates. When asked when was the last care plan meeting she attended, she stated that she could not recall attending one for the year of 2024. She explained that the facility had changes in management, and they were working on getting all care plans updated. The Unit manager also stated that the importance of a comprehensive care plan was to outline the care that residents need and to give the floor staff a path for how they were to care for residents. In an interview on 01/26/24 at 11:12 am with CNA A, she stated that Resident #2 was aggressive and thought the facility was his house. Sometimes he would have good days, but he often would get upset or triggered when people would enter his room. She explained that in the past he would try and kick his roommates out, so Resident #2 was now housed in a private room. In an interview on 01/26/24 at 12:48 pm, MDS A stated the Resident #2's care plan was not completed. She explained that she had opened his care plan to begin updates, but because he was sent out of the facility on 1/14/24 to a behavioral hospital, no one had signed or reviewed his plan of care. MDS A stated that the Unit Manager is responsible for updating the day-to-day changes in resident behaviors in the care plan. For quarterly care plans, MDS A stated that she liked to leave the care plan open for three months post the completion date so that each department head would have enough time to develop or revise the care plan. After the care plan had been revised, the social worker would reach out to the responsible party of the resident and schedule a care plan meeting in person or over the phone. MDS A explained that updates to the care plan are not her responsibility, but she was helping to get the facility up to date. Her priorities were MDS assessments, and she presented to the investigator her MDS assessments, which were last completed in November or December of 2023. Resident #3 Record Review of Resident #3's face sheet revealed a ninety-two-year-old woman admitted on [DATE]. Her admitting diagnoses were hypertension (high blood pressure), adult failure to thrive, dementia (memory loss), and cognitive communication deficit. Record review of Resident #3's care plan (revised 01/19/24) revealed that she had a diagnosis of insomnia, had a behavior problem of sitting on the floor with her legs crossed, and she was at risk for wandering related to cognitive communication deficit, dementia. Interventions for wandering included to distract resident with pleasant diversions, provide structured activities, reorientation, and identify pattern of wandering. Record review of Resident #3's progress notes revealed that on 12/30/23 and 01/05/24, resident had to be redirected more than once for wandering the unit common areas and into resident rooms. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's self-reported incident in the last 30 days revealed that on 01/14/23 at 8:50 am: Upon investigation, it was discovered that there was blood leading from Resident #2's room where Resident #3 was found lying down. There was blood in Resident #2's room as well as on the side and bottom of his trash can. Resident #3 does wander into other rooms from time to time and Resident #2 does not want anyone in his room. Resident #3 was found in another room laying down on the floor bleeding and was struck in the face. Laceration (deep cut or tear in skin) to forehead with indentation and hematoma (injury where blood collects and pool under skin), swollen nose with discoloration, skin tear to left cheek, and right foot great toe skin tear. No fractures reported by hospital. In an interview with Unit Manager on 01/26/24 at 10:53 am, she stated that Resident #3 was a wanderer with no history of aggression. Her room was located the opposite side of where she was found on 01/14/24. In an interview on 01/26/24 at 11:12 am with CNA A, she stated that Resident #2 was aggressive and thought the facility was his house. Sometimes he would have good days, but he often would get upset or triggered when people would enter his room. She explained that in the past he would try and kick his roommates out, so Resident #2 was now housed in a private room. She stated that on 01/14/24, Resident #2 was in his room waiting for breakfast and Resident #3 had wandered into his room while she was in a different resident's room, getting them up for breakfast. Resident #2 resided in the very last room on that hall, and he normally would eat his breakfast in solitude inside his room. CNA A said that she did see Resident #3 sitting on the floor of another resident's room (a care planned behavior), but she immediately did not do anything because she did not see any signs of distress and that is what she does. After she finished assisting another resident, she went down the hall to redirect Resident #3 and saw that she was bleeding from her head. She followed a trail of blood across the hall to Resident #2's room and saw that there was blood on the trash can. CNA A called the nurse and Resident #3 was assessed and sent out to the hospital for evaluation. Resident #2 was sent out that day to a behavioral health hospital for medication review and a psychiatric evaluation. The other nurses in the memory care unit did not see the incident and were passing morning medications at that time and no one heard any yells or noises from an altercation. Record review of the facility's policy titled Care Plans, Comprehensive Person- Centered, revised March 2022, displayed: 1. The comprehensive, person-centered care plan: a. includes measurable objectives and time frames; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 2. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 3. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 4. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 5. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. 6. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. This was determined to be an Immediate Jeopardy (IJ) on 02/14/24 at 10:45 am. The Admin and Corporate Nurse (CN) were notified. The Admin and Corporate Nurse (CN) were provided with the IJ template on 2/14/24 at approximately 10:45 am. The following POR (Plan of removal) submitted by the facility was accepted on 02/16/24 at 01:45 pm. The POR documented: The facility failed: to supervise resident #3 from wandering into resident #2 rooms where she was injured and had to be sent to the hospital. Immediate action: resident #3 discharged to the hospital and resident #2 was sent to Oceans behavioral hospital for evaluation and treatment 1-14-2024. Resident #3 has been discharged not to return discharged on [DATE]. Resident #2 is stable and has not had any further behaviors went to Oceans Behavioral hospital on 1-14-24 and returned on 1-26-2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Audit on the memory care unit initiated on 2-14-2024 by the in house MDS nurse. 30 residents reside on the memory care unit. The corporate MDS nurse came in on 2/15/2024 to assist with the audit process. All residents on the memory care unit have potential to wander. 13 out of 30 residents identified actively wander in the unit. The care plans for these 13 residents were reviewed and updated. 2/16/2024 Staffing Ratios were reviewed to ensure the facility has adequate staffing ratios. Staffing Ratios for the Memory Care Unit-3 aides 2 nurses and 1 activity staff on unit for increased supervision. This is the normal staffing pattern on the memory Care unit. o 6-2 (3 aides and 2 nurses 1 activity) o 2-10 (3 aides 2 nurses, activity leaves at 6pm) o 10-6 (one nurse and 2 aides) 2/15/2024 Regional MDS coordinator in facility to assist with identifying residents with wandering behaviors to ensure appropriate care planning is in place and accurate. 2/15/2024 Review of the SOM 689 accidents hazards/supervision/devices/with the Clinical team on 2/16/2024 at 0900 the department heads and the clinical team reviewed on the big screen TV the 689 regulation to validate 2-15-2024. This will be accomplished by reading the regulation in full and the critical pathway for Accidents will be reviewed verbally as a team. This will ensure that we have all the elements of training covered in the Pathway and additional training needed if necessary. Medical Director was notified on 2/14/2024 of IJ 689 Follow up with the medical director on 2/15/2024 @ 8:15am on IJ status. AD Hoc QAPI to be held 2/16/2024 with F-689 and SOC update on IJ reviews. An in-service initiated by the memory care RN, ADON - for increased monitoring of wandering residents, in the dining areas, and common areas and re-direction of the resident. All staff on 100-200-and 300 halls were in-serviced because the staff at any given moment could float to another unit. Central Supply and medical records assigned to assist with daily rounding in the unit until all walkie talkies are in place 2-14-2024 to 2-16-2024. New Weekend Supervisor starting on 2/17/2024 to provide supervisory coverage of the buildings on the weekends, 16-hour shifts. Both ladies are already assigned ambassadors to the memory care unit. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	They round before the morning meeting. After the morning meeting After Lunch And before they leave for the day Both offices are located in the same vicinity of the memory care unit. Walkie talkies (ordered on 2/15/2024) to be delivered on 2/16/2024: to be used by the aides and the nurses to communicate with each other. when a resident wanders from the group setting, during rounds, in passing etc. so that the all staff will be able to keep closer monitoring on the wandering residents. 3 Walkie talkies are being charged for use on 2/15/204 and the other 5 are being delivered on 2/16/2024. Monitoring form initiated for rounds every hour to ensure that nurses can document that they are monitoring and rounding in the unit .at night the nurse will continue with the monitoring while the resident is asleep. 2/15/2024 we will continue the monitoring until we receive the equipment on 2/16/2024 and will continue the rounding until the staff is using the walkie talkies appropriately. CN completed the initial training with the nurses and aides on the use of the walkie talkies . 2 placed on 300 once sufficiently charged. Completion date of training will be completed on 2/16/2024. Following acceptance of the facility's Plan of Removal, the facility was monitored from 02/16/24 to 02/17/24. Monitoring of the plan of removal included: The surveyor confirmed the facility implemented their plan of removal sufficiently from 02/16/24 - 02/17/24 to remove the IJ by: Monitoring Day 1: 02/16/24 Record review of the care plans for residents on the MC unit who have the potential to wander (13) were updated and made available for care staff on PCC through the kiosk. Record review of the in-services conducted 02/13/24 on F-0656 Develop and Implement Comprehensive Care Plans displayed 14 of 14 management, nursing staff, and assistant nursing directors, the social worker, and therapy department heads were educated. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #2's care plan documented that Resident #2 had the potential to be physically aggressive related to history of harm to others and poor impulse control. Interventions included to utilize behavior interventions to manage episodic behaviors, engage calmy in conversation, guide away from source of distress, and intervene before agitation escalates. Care plan also stated the goal for Resident #2 would be no harming of himself or others through the review date. Care plan documented that the resident had the potential to be verbally aggressive and listed interventions such as assess and anticipate resident needs, allow time for the resident to express self and feelings towards the situation, and administer medications as needed. Resident #2 Care plan was updated on 2/12/24. Record review of Resident #2's MDS revealed that this assessment was updated on 01/31/24. In an interview with Resident #2 on 02/14/24 at 11:58am, he stated that he was doing alright and that he was feeling relaxed without any pain. He stated that he vaguely remembered an incident with another resident and a trash can but cannot remember exactly what happened. On 02/15/24 a set of 12 long range rechargeable walkie talkies with batteries were purchased from an online vendor. On 02/16/24, walkie talkies arrived at the facility, were charged, and placed within the MC Unit. Record review of an in-service titled Supervision was started on 02/16/24. This in-service covered reasons why residents wander, hourly rounds on residents and management, redirecting residents who wander, and the use of walkie talkies on the MC Unit. Record review of Resident #2 monitoring sheets displayed that resident was checked every 30 minutes. No new behaviors or changes noted. Record review of newly hired RN weekend supervisor, start date 02/17/24. Sex offender registry, EMR, and license verification report completed. Monitoring Day 2: 02/17/24 Record review of an in-service titled Supervision was completed on 02/17/24. Sign in sheets showed a total of 80 staff who provide direct care or nursing services. In an interview with CNA F on 02/17/24 at 5:30pm, she stated that she worked the 10pm- 6am shift. She was informed on how to use the walkie and the purpose was for staff to be able to monitor residents in the MC Unit who may wander. She explained that sometimes residents will wander because they are looking for family and you may be able to help with a phone call. If a resident is aggressive with another resident, she will intervene to ensure the safety of that resident. If a resident is showing aggression towards herself, she would walk away and reapproach later. In an interview with CNA G on 02/17/24 at 5:35 pm, she stated that she worked the 6pm-2am shift. She explained that a resident may wander because of hunger, or they may need to be changed. If she witnessed this behavior, she would try to redirect them or offer them a snack. She stated she normally worked on a hall without wandering residents, so if she noticed this behavior, she would chart it in PCC and immediately inform her charge nurse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with CNA H on 02/17/24 at 5:39 pm, she stated that she worked the 2pm- 10pm shift and that she was told to redirect and offer snacks to residents who wander. It was important to know where residents are at all times and wanderers have a wander band that goes off when they come too close the door. If she had a resident that started to walk around aimlessly, she would try to toilet them, offer snacks, and let her charge nurse know. Then she would chart it in PCC. In an interview with LVN B on 02/17/24 at 5:47 pm, she stated that she worked the 6am- 2pm shift. She explained that in the in-service, they talked about the locked unit and that staff was responsible to do checks on residents. They must have a person supervising the MC Unit and they will use the walkies to alert other people that the resident was walking around. The walkie talkies help staff better communicate with each other. In an interview with CNA I on 02/17/24 at 5:53 pm, she stated that she worked the 10pm- 6am shift. She explained that she normally worked the 10pm-2am shift. In the in-services given, she was informed that if she saw a resident wandering, she was to redirect and see if she could meet their needs. She explained that if she noticed a resident on her unit (non MC hall) began to wonder, she would tell her charge nurse immediately of the unusual behavior and chart it in the kiosk. In an interview with LVN C on 02/17/24 at 6:07 pm, she stated that she is a nurse in the MC unit who normally worked the 2pm-10pm shift. She stated that in the in-services, she was taught to redirect all residents who are seen wandering by offering them snacks, toileting, redirection, and assessing pain levels. In an interview with RN A on 02/15/24 at 6:12 pm, he stated that he worked the 2pm to 10pm shift. He explained that if staff saw somebody wondering, they investigate why, and see if they are hungry or want to be changed. Staff will check the diapers to see if they are wet, offer food and snacks, see if they are looking for someone to talk to, or try to find out what they want. The unit was given walkies that work by pushing the side button and talking. MC staff know that his cart is in front of the nurse's station on the MC Unit. If he left to go to another area, MC staff can walkie him. If the aid in the dining area saw a resident in the front room leaving out, all MC staff must acknowledge that that can hear the staff letting them know a resident was on the move and to keep eyes on them. In an interview with LVN D on 02/17/24 at 6:45 pm, she stated that she worked the 6am- 10:30pm shift on Saturday and Sundays. She stated that in the in-service given on 2/16/24, her takeaways were that wandering behaviors in a resident may be related to an underlying factor. Staff should check and see if they resident needs to be changed, offer snacks, monitor their whereabouts, then redirect them. She also explained that the behavior could also be as simple as the resident looking for someone to talk to. She also stated that the MC unit had walkie talkies now, which will help staff communicate on where the residents are and what they may need. In an interview with CNA J on 02/17/24 at 6:50 pm, she stated that she worked the 2pm-10pm shift. She was in serviced on residents who wander and informed to redirect them when this behavior is noticed. She explained that if a resident fights, staff should separate them and try to see if they would like to participate in an activity or if they would like a snack. Immediately after, this behavior should be reported to the nurse and updated on the Kardex in PCC. (continued on next page)

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	675789	A. Building B. Wing	02/19/2024

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Corporate Nurse was informed the Immediate Jeopardy (IJ) was removed on 02/17/24 at 7:00 pm. The facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not an Immediate Jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561 Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet residents' mental and psychosocial needs, for two (Resident #2 and #3) of eight residents reviewed for care plans. 1.) The facility failed to update Resident #2's care plan after he demonstrated a history of aggressive behaviors regarding resident care and his personal space to staff and residents. 2.) The facility failed to include that Resident #3 was a fall risk in the care plan. On 02/12/24 at 01:50 pm an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 02/15/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not an Immediate Jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk by not receiving appropriate treatment and services to meet their needs. Findings included: Resident #2 Record Review of Resident #2's face sheet revealed an eighty-four-year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), generalized anxiety disorder, and hyperlipidemia (high cholesterol). Record review of Resident #2's care plan (completed 7/20/23, revised 01/15/24) revealed that he was incontinent, had a communication problem, had acute/chronic pain, and was a wanderer and an elopement risk. No focus areas specified anything regarding resident behaviors. Record Review of Resident #2's BIMS (Brief Interview for Mental Status test, used to get a quick snapshot of a residents cognitive status) revealed a score of 3.0 on a scale range from 1.0- 15.0. Record review of Resident #2's progress notes revealed the following: 07/26/23 documented by a nurse (name unknown): Resident roommate is in dining room eating dinner. And Resident #2 is sitting on roommate bed eating his dinner. Writer explains to resident that's not his bed. Resident #2 states fuck this shit, I can stay in this bed, you can't tell me what the fuck to do! Staff redirects resident, but resident still refuses to go his own bed. Resident #2 states This is my place and all these beds is mine! Writer notifies Administrator of Resident #2 non-compliance to go his own bed. And Resident #2 is getting agitated with staff. Roommate moved to other room due to roommate Resident #2s refusal to go to his own bed. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	09/04/23 documented by a nurse (name unknown): Resident in Room and resident very territorial about his room. Even if resident just comes to his doorway. Resident begins to curse stating quotation I don't want any of you bitches coming in my room!. Staff has to redirect resident. Resident states to staff I'm going to kick all you mother fuckers ass!. Staff has to redirect resident. Staff was trying to pick up resident dinner tray from his room. And resident refused to allow staff in room. Resident sat stuff on floor in room, blocking staff from trying to pick up his finished dinner tray in room. Staff again redirected resident. Resident remained verbally combative towards staff. Staff will continue to redirect and monitor. 9/14/23 documented by a nurse (name unknown): Staff has to redirect resident. Resident forgets what side room is on. Resident denies he lives here; staff again redirect their resident. Resident verbally combative towards staff and using profane language too; staff will continue to redirect and monitor. 10/04/23 documented by a nurse (name unknown): Resident stayed in his room asleep all through the night. Earlier during change of shift walking rounds, observed resident blocked his door with bedside table and by opening the rest room door, puts a sling on the door making it difficult to open. He mentioned that he don't like other residents wandering into his room and that's why he wants the door closed. Staff encouraged resident not to put ant thing that will make it difficulty in opening the door for his own safety as well, staff will keep an eye on other residents as to not wander into his room and if by any chance, any resident wanders into his room, to use his call button to call on staff who will assist in getting unwelcomed resident out of his room of which he agreed to. 10/27/23 documented by a nurse (name unknown): Other male resident from other room on station D wandered into room A. Resident #2 yelling at the resident to get out of his room. Staff intervenes to get other resident out of room. When resident #2 picks-up a plastic hanger and starts swinging the hanger towards the staff members only yelling you bitches get the fuck out my room! Writer explains to resident #2 of trying to get other resident out of his room, please be patient. Writer and staff continue to attempt to remove other resident from room. And resident #2 continues to swing plastic hanger toward staff members only referring to staff members as Bitches, Ugly [NAME]! Finally staff able to remove other resident from room and transfer back to their room. Resident #2 didn't exhibit any physical aggression of swinging hanger toward resident; physical aggression of swinging plastic hanger directed only towards staff members; will continue to monitor. 11/03/23 documented by the Social Worker: Staff reports that resident is much calmer but at a time has exhibited threatening behavior including cursing and swinging plastic hangers at staff during intervention with another resident. Met with resident who is alert, able to let staff know of his needs, talking in a very long time, requires assistance and cuing with ADL and encouragement to take his meds. Educated him to refrain from threatening with an object and he doesn't recall any verbal or physical behavior and sits in day area and participates in activities when encouraged. He is under the services of guardianship program message left related to his behavior and referral for further evaluation and treatment. Resident is under psych/ nurse practitioner care for medication and referral to senior psychology for psychological services and to manage plan. Resident to remain in memory care due to wandering risk, full code and LTC. No DC plan. Staff to approach in a calm and non-threatening monitor and redirect as needed. 11/15/23 documented by a nurse (name unknown): resident refuses to take shower according to CNA. Resident frequently urinates on the floor in his room period no other behaviors noted. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	11/17/23 documented by a nurse (name unknown): resident refused to take shower/bath. Writer explained the importance of bathing but residents still refused. 11/20/23 documented by a nurse (name unknown): resident refused morning medication despite writer explaining importance of them. Has tendency to spit out medication after putting them in his mouth. Resident currently in his room will continue to monitor. 01/14/24 documented by the Social Worker: staff report that Resident #2 was involved in a physical altercation with another resident and placed under behavioral and safety monitoring. The resident has a long history of mental disorders including paranoid schizophrenia and mood disorder but med intervention in progress. Due to his current behavior, he may need further evaluation for placing self and others in danger. Social workers spoke to behavioral staff to assess for possible inpatient eval and treatment for current signs of mental illness. Behavioral hospital accepted him for care. Nursing notified as accepting psychiatrist, accepting administrator to get transportation and transfer resident to behavioral hospital. Record review of the facility's self-reported incidents in the last 30 days revealed: 01/07/24 at 2pm: Resident #2 and another resident were tugging back and forth over a piece of clothing that came from Resident #2's room, when Resident #2 stumbled backwards and hit his head on the door. Resident #2 was admitted to the hospital with traumatic brain injury assault with brain bleed called subdural hemorrhage (bleeding between the brain and the skull) and subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane). 01/14/23 at 8:50 am: Upon investigation, it was discovered that there was blood leading from Resident #2's room where Resident #3 was found lying down. There was blood in Resident #2's room as well as on the side and bottom of his trash can. Resident #3 does wander into other rooms from time to time and Resident #2 does not want anyone in his room. Resident #3 was found in another room laying down on the floor bleeding and was struck in the face. Laceration (deep cut or tear in skin) to forehead with indentation and hematoma (injury where blood collects and pool under skin), swollen nose with discoloration, skin tear to left cheek, and right foot, great toe skin tear. No fractures reported by the hospital. Record review of Resident #2's psychiatric evaluation visit dated 01/03/24 revealed that there had been no changes in behaviors since his GDR of sertraline. Resident had been calm and no mood adjustments. In the care plan recommendations, it stated that the resident was not an acute danger to himself or others, but this may change due to psycho stressors and treatment compliance. Other recommendations included managing the resident's environment, utilizing behavior interventions for episodic behavior, and provide supportive encouragement to increase socialization. In an interview on 01/26/24 at 10:48 am, the Unit Manager stated that since she was promoted into the Unit Manager role in November 2023, Resident #2 refused care and was sometimes aggressive with staff, but he was doing well before his most recently reported incident on 01/14/24. Resident #2 was mild mannered and could sometimes be easy to redirect. The unit manager was not aware if Resident #2 had any behavioral ticks and stated that he was in a room without a roommate by chance and not for any specific reason. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 01/26/24 at 10:53 am, the Unit Manager stated that the facility staff did care plan meetings everyday where they discuss the needs of different residents with the social worker, nurses, and therapist if they were in therapy. The Unit Manager explained that she was responsible for making acute (day to day changes/trends) to the care plan, while each department head had their own sections for updates. She stated that she could not recall attending a care plan meeting for the year of 2024. She explained that the facility had changes in management, and they were working on getting all care plans updated. The Unit manager also stated that the importance of a comprehensive care plan was to outline the care that residents needed and to give the floor staff a path for how they were to care for residents. In an interview on 01/26/24 at 11:12 am with CNA A, she stated that Resident #2 was aggressive and thought the facility was his house. Sometimes he would have good days, but he often would get upset or triggered when people would enter his room. She explained that in the past he would try and kick his roommates out, so Resident #2's roommate was placed in a different room and he was now housed in a private room. In an interview on 01/26/24 at 12:48 pm, MDS A stated that Resident #2's care plan was not completed. She explained that she had opened his care plan to begin updates, but because he was sent out of the facility on 1/14/24 to a behavioral hospital, no one had signed or reviewed his plan of care. MDS A stated that the Unit Manager was responsible for updating the day-to-day changes in resident behaviors in the care plan. For quarterly care plans, MDS A stated that she liked to leave the care plan open for three months post the completion date so that each department head would have enough time to develop or revise the care plan. After the care plan had been revised, the social worker would reach out to the responsible party of the resident and schedule a care plan meeting in person or over the phone. MDS A explained that updates to the care plan were not her responsibility, but she was helping to get the facility up to date. Her priorities were MDS assessments, and she presented to the state investigator her MDS assessments, which were last completed in November or December of 2023. Resident #3 Record Review of Resident #3's face sheet revealed a ninety-two-year-old woman admitted on [DATE]. Her admitting diagnoses were hypertension (high blood pressure), adult failure to thrive, dementia (memory loss), and cognitive communication deficit. Record review of Resident #3's care plan (revised 01/19/24) revealed that she had diagnoses of insomnia, has a behavior problem of sitting on the floor with her legs crossed, and she was at risk for wandering related to cognitive communication deficit, dementia. No focus area was initiated for falls. Record review of Resident #3's Fall risk evaluation (ranged 1.0- 15.0) revealed the following: 1/14/2024 N Adv - Fall Risk Evaluation at Risk 10.0 12/28/2023 N Adv - Fall Risk Evaluation No risk 2.0 12/27/2023 N Adv - Fall Risk Evaluation at Risk 13.0 12/27/2023 N Adv - Fall Risk Evaluation at Risk 14.0 (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	12/25/2023 N Adv - Fall Risk Evaluation at Risk 10.0 12/25/2023 N Adv - Fall Risk Evaluation at Risk 11.0 8/20/2023 N Adv - Fall Risk Evaluation at Risk 14.0 Record review of the facility's Incident and Accident Log from 08/24/23- 01/24/24 for Resident #3 revealed: Injury of Unknown Origin Cause Incidents 09/10/23 12/25/23 Other incidents 01/14/24 In an interview on 01/26/24 at 10:53 am with the Unit Manager, she stated that Resident #3 was a fall risk. In an interview on 01/26/24 at 11:22 am with CNA A, she stated that Resident #3 was a fall risk. In an interview on 01/26/24 at 10:53 am, the Unit Manager stated that the facility staff did care plan meetings everyday where they discuss the needs of different residents with the social worker, nurses, and therapist if they were in therapy. The Unit Manager explained that she was responsible for making acute (day to day changes/trends) to the care plan, while each department head had their own sections for updates. She stated that she could not recall attending a care plan meeting for the year of 2024. She explained that the facility had changes in management, and they were working on getting all care plans updated. Since the Unit Manager had gotten her promotion to this role in 11/2023, she had not noticed any behavior issues with Resident #2. The Unit manager stated that the importance of a comprehensive care plan was to outline the care that residents needed and to give the floor staff a path for how they were to care for residents. In an interview on 01/26/24 at 12:39 pm, MDS A stated that when she started at the facility in September 2023, that a lot of care plans had not been completed in some time due to a gap in employment. MDS A stated that the Unit Manager is responsible for updating the day-to-day changes in resident behaviors in the care plan. For quarterly care plans, MDS A stated that she liked to leave the care plan open for three months post the completion date so that each department head would have enough time to develop or revise the care plan. After the care plan had been revised, the social worker would reach out to the responsible party of the resident, and schedule a care plan meeting in person or over the phone. MDS A explained that updates to the care plan were not her responsibility, but she was helping to get the facility up to date. Her priorities were MDS assessments, and she presented to the state investigator her MDS assessments, which were last completed in November or December of 2023. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 01/26/24 at 3:38 pm with the Admin, she stated that she had been employed at the facility since December of 2023. She explained that she was aware that care plans were behind and that the facility had implemented a PIP to get back on track. The Unit Manager of each unit was responsible for updating the care plan with day-to-day changes while each department head was to update the other sections (activities, nursing, dietary, and therapy). She explained that the harm in not having updated care plans was that staff would not have special instructions to handle the needs of each resident. Record review of the facility's policy titled Care Plans, Comprehensive Person- Centered, revised March 2022, displayed: 1. The comprehensive, person-centered care plan: a. includes measurable objectives and time frames; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 2. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 3. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 4. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 5. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. An Immediate Jeopardy (IJ) was determined on 02/12/24. The Admin and Corporate Nurse (CN) were notified. The Admin and Corporate Nurse (CN) were provided a template on 2/12/24 at approximately 1:50 pm. The following POR (Plan of removal) submitted by the facility was accepted on 02/14/24 at 10:53 am. The POR documented: The facility failed to care plan and implement interventions for Resident #2 who had behaviors. Immediate action: F0656- Develop and Implement Comprehensive Care Plans Resident #2 Care plan was updated on 2/12/2024. Audit initiated on 2-12-2024 of residents with behaviors to determine that their plan of care is accurate with interventions. The Nurse Managers, the MDS team, the social workers, the wound care nurse identified 33 care plans for residents with identified behaviors and are in the process of being reviewed. Completion 2/14/2024. The MDS team, ADON#1, ADON#2, ADON#3, the Wound Care Coordinator, the Social Worker, Activities, Dietary, and Therapy, were in-serviced on care planning and comprehensive person-centered care, baseline care plans, and review of the State operation Manual F656. 2-12-2023 Chief Nursing Officer. The floor nurses and the aides will be re-educated on the care plan process as well as how to access the resident care plan in PCC as well as the Kardex. The charge nurse and the aides will be educated on how to notify the DON, the charge nurse, the unit manager, the MDS nurse for any information needed to be added or removed from the plan of care clinical management team. 2-14-2024 The DON/Designee will ensure that care plans are completed timely, the accuracy of the MDS is the responsibility of the person completing the MDS. Care plan will be updated quarterly and as needed with any acute changes prior to the next assessment period. Resident #2 has been readmitted , is stable, and has had no new behaviors. He had medication adjustments in the hospital and was seen by the Geri-med psych team when readmitted . Resident #3 has been discharged . Medical Director was notified on 2/12/2024. The person-centered comprehensive care plan has been reviewed and updated to reflect Resident #2 current medical, physical, mental, and psychosocial needs and status as of February 12, 2024. An in-service for interdisciplinary team members for the regulatory requirement for developing and implementing comprehensive care plans cited under 42 CFR S483.21(b)(1) was completed on February 12, 2024, by Chief Nursing Officer. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A performance improvement plan (PIP) for timely completion and review of care plans was initiated on November 21, 2023, with a target completion date of March 04, 2024. The facility team members are actively engaged in the PIP. As of February 12, 2024, the PIP is ongoing and on track. Following the acceptance of the facility's Plan of Removal, the facility was monitored from 02/14/24 to 02/15/24. Monitoring of the plan of removal included: The surveyor confirmed the facility implemented their plan of removal sufficiently from 02/14/24 - 02/15/24 to remove the IJ by: Monitoring Day 1: 02/14/24 Record review of care plans for 33 residents with behaviors were conducted. All care plans were updated by interdisciplinary teams and the MDS Nurse and MDS Coordinator. Record review of the PIP (Performance Improvement Plan) for timely completion and review of care plans (initiated on November 21, 2023) revealed a target completion date of 03/04/24 and was on track. Record review of the in-services conducted 02/13/24 on F-0656 Develop and Implement Comprehensive Care Plans displayed 14 of 14 management, nursing, and assistant nursing directors, the social worker, and therapy department heads were educated. Record review of the in-services conducted 02/13/24 titled How to access care plans for nurse and CNA's revealed 57 nurses and certified nurse aids were educated on how to log into PCC and review each resident's care plan when assisting with care and specified needs. Record review of Resident #2's care plan documented that Resident #2 had the potential to be physically aggressive related to history of harm to others and poor impulse control. Interventions included to utilize behavior interventions to manage episodic behaviors, engage calmly in conversation, guide away from source of distress, and intervene before agitation escalates. Care plan also stated the goal for Resident #2 would be no harming of himself or others through the review date. Care plan documented that the resident had the potential to be verbally aggressive and listed interventions such as assess and anticipate resident needs, allow time for the resident to express self and feelings towards the situation, and administer medications as needed. Resident #2 Care plan was updated on 2/12/24. Record review of Resident #2's MDS revealed that this assessment was updated on 01/31/24. In an interview with Resident #2 on 02/14/24 at 11:58 am, he stated that he was doing alright and that he was feeling relaxed without any pain. He stated that he vaguely remembered an incident with another resident and a trash can but cannot remember exactly what happened. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Wood	8810 Long Point Dr 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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with Nurse A on 02/14/24 at 12:03 pm, she stated that she worked in the MC Unit, and she was in-serviced on working with behavior management patients, when to review psychotropic medications, and on admission staff are to do the baseline care plans to monitor and see if Residents have any side effects or any behaviors that need to be addressed. If there is any type of new behavior, staff is to first contact the doctor or the psych nurse if it is a psych related issue. Staff will then do a progress note and we do a change in condition in PCC. She stated that nurses may to have get a new medication order from the doctor, then take it from there. If it is a new behavior that required a new intervention, every 15 minutes staff will do close monitoring of those behaviors. She explained that since Resident #2 has returned, he stays in his room, and has not had any behavior issues. He was prescribed Depakote and that has helped a lot. In an interview with LVN A on 02/14/24 at 12:20 pm in the MC unit, she stated that she had received an in-service on safety and aggressive behaviors. She was taught to redirect residents and calm them down. Anytime we see residents not doing what they were supposed to do, we would alert the DON. We know to let the DON know when the behaviors were a danger to the resident. We don't wait until it gets to the climax but if the behavior is escalating. Staff know to review the shift reports to monitor the progress notes. At the end of every shift, we have a report for each resident. We talk about it nurse to nurse and have the report. Then we just keep our eyes open. In an interview on 02/14/24 at 12:30pm in the MC Unit, she stated that in her in-service, she discussed resident behaviors, and they talked about each individual resident in the MC unit. She was asked to pull up the care plan from the kiosk and did so successfully. She stated that she will report any type of change in behavior pattern to her charge nurse immediately. These behaviors could range from a decline in eating or agitation. Day 2: 02/15/24 In an interview with ADON A on 02/15/24 at 12:45 pm revealed that she was in-serviced on updating acute changes in behaviors for all residents and making sure the interventions were followed through. If there were any changes with residents, care staff were to come to nursing managers directly and they can document it on the kiosk with PCC or on the written form kept at the nurse's station. She explained that she gave an in-service to the nurses and CNA's who were assigned to the 200-hall. This in-service covered how to access the resident care plans by using the kiosk and the facility's new Stop and Watch alert tab located on the kiosk which will allow staff to document any changes in behavior. In an interview on 02/15/24 at 12:52 pm with the WCN, she explained that in the most recent in-service, they went over the protocols for going through the care plans during morning meetings and when the doctor comes. During those meetings, staff will talk about what needs to be updated, if there were any changes in conditions, and make sure all updates re done daily. In an interview on 02/15/24 at 12:58 pm with the MDS Nurse and R-MDS Nurse, the following things were revealed: -Each section of the care plan will be done by the IDT team and they must sign off on it. The care plan is to be done after The MDS assessment. The MDS assessment comes directly from PCC. Once the MDS is completed, we roll it over in the care plan. Anything that is acute, or a change should be updated as it comes in. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-All acute documentation should be timely and immediately. Updates should be addressed in the first few hours in the care plan. Interventions can be changed or taken away as needed. -Every week a weekly report will be sent out that goes to the Corporate Nurse, the ADON, and certain team members. R-MDS will pull a report for care plans due for that week or change in conditions from PCC. If past due, the report will be highlighted in red on the dashboard. This will allow all staff to go through and make sure they have their section cleared by the review date. This was started on 01/8/24 to help them focus on their needs for that week. -Once the MDS Coordinator and the MDS nurse receive the report, they communicate with the IDT team via email. The MDS Coordinator will open reviews for those residents and the IDT will go in and update that review. This system has become very effective in care plan completions and getting back on track. -The accuracy of care plans will be ensured during the reviews. Once it is signed, the care plan should reflect the most up to date version of the MDS. The care plan review on the MDS side will be done every 92 days, then they will open the care plan to be reviewed by the IDT staff. In an interview with the AD on 02/15/24 at 01:24 pm, she stated that she was shown how to view the care plan on the kiosk, and she was re-educated on putting more information on the care plan and how to enter it so that all care staff were able to view it on PCC at the kiosk. When there was a change in condition, she will report it to the charge nurse and tell it to the DON and the Admin. The AD stated that she reports both verbally and documents in the progress notes under that resident. She explained that she ensured her part was accurate because she goes through each resident on a list and reviewed their behaviors with the two other staff who work in activities. One activities member who provides direct care with residents was also present to provide firsthand information. In an interview on 02/15/24 with the MC Unit Manager, she stated that all staff were made aware of what their responsibilities were in regard to care planning, including antibiotic therapy, falls, behavior changes, and acute changes. Care plan meetings will be done daily. Staff know to notify the Unit Manager. This should also be notated in the nursing notes. In an interview on 02/15/24 started at 2:17 pm with CNA C, CNA D, CNA E, CNA F, CNA G, CNA H, and CNA I, each CNA was able to pull up resident care plans through PCC using the kiosk. The Corporate Nurse was informed the Immediate Jeopardy (IJ) was removed on 02/15/24 at 3:12 PM. The facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not an Immediate Jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46561 Based on interview and record review the facility failed to review and revise the person-centered care planning for one (Resident #2) of eight residents reviewed for care plan revision. 1. Resident #2's care plan had not been revised to include behavioral triggers and aggression. On 02/12/24 at 01:50 pm an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 02/15/24, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not an Immediate Jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk for decreased quality of care and quality of life. Findings included: Resident #2 Record Review of Resident #2's face sheet revealed an eighty-four-year-old man who was admitted to the facility on [DATE]. His admitting diagnoses were schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), generalized anxiety disorder, and hyperlipidemia (high cholesterol). Record review of Resident #2's care plan (completed 7/20/23, revised 01/15/24) revealed that he was incontinent, had a communication problem, had acute/chronic pain, and was a wanderer and elopement risk. No focus areas specified anything regarding resident behaviors. Record Review of Resident #2's BIMS (Brief Interview for Mental Status test, used to get a quick snapshot of a residents cognitive status) revealed a score of 3.0 on a scale range from 1.0- 15.0. Record review of Resident #2's progress notes revealed the following: 07/26/23 documented by a nurse (name unknown): Resident roommate is in dining room eating dinner. And Resident #2 is sitting on roommate bed eating his dinner. Writer explains to resident that's not his bed. Resident #2 states fuck this shit, I can stay in this bed, you can't tell me what the fuck to do! Staff redirects resident, but resident still refuses to go his own bed. Resident #2 states This is my place and all these beds is mine! Writer notifies Administrator of Resident #2 non-compliance to go his own bed. And Resident #2 is getting agitated with staff. Roommate moved to other room due to roommate Resident #2s refusal to go to his own bed. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	09/04/23 documented by a nurse (name unknown): Resident in Room and resident very territorial about his room. Even if resident just comes to his doorway. Resident begins to curse stating quotation I don't want any of you bitches coming in my room!. Staff has to redirect resident. Resident states to staff I'm going to kick all you mother fuckers ass!. Staff has to redirect resident. Staff was trying to pick up resident dinner tray from his room. And resident refused to allow staff in room. Resident sat stuff on floor in room, blocking staff from trying to pick up his finished dinner tray in room. Staff again redirected resident. Resident remained verbally combative towards staff. Staff will continue to redirect and monitor. 9/14/23 documented by a nurse (name unknown): Staff has to redirect resident. Resident forgets what side room is on. Resident denies he lives here; staff again redirect their resident. Resident verbally combative towards staff and using profane language too; staff will continue to redirect and monitor. 10/04/23 documented by a nurse (name unknown): Resident stayed in his room asleep all through the night. Earlier during change of shift walking rounds, observed resident blocked his door with bedside table and by opening the rest room door, puts a sling on the door making it difficult to open. He mentioned that he don't like other residents wandering into his room and that's why he wants the door closed. Staff encouraged resident not to put ant thing that will make it difficulty in opening the door for his own safety as well, staff will keep an eye on other residents as to not wander into his room and if by any chance, any resident wanders into his room, to use his call button to call on staff who will assist in getting unwelcomed resident out of his room of which he agreed to. 10/27/23 documented by a nurse (name unknown): Other male resident from other room on station D wandered into room A. Resident #2 yelling at the resident to get out of his room. Staff intervenes to get other resident out of room. When resident #2 picks-up a plastic hanger and starts swinging the hanger towards the staff members only yelling you bitches get the fuck out my room! Writer explains to resident #2 of trying to get other resident out of his room, please be patient. Writer and staff continue to attempt to remove other resident from room. And resident #2 continues to swing plastic hanger toward staff members only referring to staff members as Bitches, Ugly [NAME]! Finally staff able to remove other resident from room and transfer back to their room. Resident #2 didn't exhibit any physical aggression of swinging hanger toward resident; physical aggression of swinging plastic hanger directed only towards staff members; will continue to monitor. 11/03/23 documented by the Social Worker: Staff reports that resident is much calmer but at a time has exhibited threatening behavior including cursing and swinging plastic hangers at staff during intervention with another resident. Met with resident who is alert, able to let staff know of his needs, talking in a very long time, requires assistance and cuing with ADL and encouragement to take his meds. Educated him to refrain from threatening with an object and he doesn't recall any verbal or physical behavior and sits in day area and participates in activities when encouraged. He is under the services of guardianship program message left related to his behavior and referral for further evaluation and treatment. Resident is under psych/ nurse practitioner care for medication and referral to senior psychology for psychological services and to manage plan. Resident to remain in memory care due to wandering risk, full code and LTC. No DC plan. Staff to approach in a calm and non-threatening monitor and redirect as needed. 11/15/23 documented by a nurse (name unknown): resident refuses to take shower according to CNA. Resident frequently urinates on the floor in his room period no other behaviors noted. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	11/17/23 documented by a nurse (name unknown): resident refused to take shower/bath. Writer explained the importance of bathing but residents still refused. 11/20/23 documented by a nurse (name unknown): resident refused morning medication despite writer explaining importance of them. Has tendency to spit out medication after putting them in his mouth. Resident currently in his room will continue to monitor. 01/14/24 documented by the Social Worker: staff report that Resident #2 was involved in a physical altercation with another resident and placed under behavioral and safety monitoring. The resident has a long history of mental disorders including paranoid schizophrenia and mood disorder but med intervention in progress. Due to his current behavior, he may need further evaluation for placing self and others in danger. Social workers spoke to behavioral staff to assess for possible inpatient eval and treatment for current signs of mental illness. Behavioral hospital accepted him for care. Nursing notified as accepting psychiatrist, accepting administrator to get transportation and transfer resident to behavioral hospital. Record review of the facility's self-reported incidents in the last 30 days revealed: 01/07/24 at 2pm: Resident #2 and another resident were tugging back and forth over a piece of clothing that came from Resident #2's room, when Resident #2 stumbled backwards and hit his head on the door. Resident #2 was admitted to the hospital with traumatic brain injury assault with brain bleed called subdural hemorrhage (bleeding between the brain and the skull) and subarachnoid hemorrhage (bleeding in the space between the brain and the surrounding membrane). 01/14/23 at 8:50 am: Upon investigation, it was discovered that there was blood leading from Resident #2's room where Resident #3 was found lying down. There was blood in Resident #2's room as well as on the side and bottom of his trash can. Resident #3 does wander into other rooms from time to time and Resident #2 does not want anyone in his room. Resident #3 was found in another room laying down on the floor bleeding and was struck in the face. Laceration (deep cut or tear in skin) to forehead with indentation and hematoma (injury where blood collects and pool under skin), swollen nose with discoloration, skin tear to left cheek, and right foot, great toe skin tear. No fractures reported by the hospital. Record review of Resident #2's psychiatric evaluation visit dated 01/03/24 revealed that there had been no changes in behaviors since his GDR of sertraline. Resident had been calm and no mood adjustments. In the care plan recommendations, it stated that the resident was not an acute danger to himself or others, but this may change due to psycho stressors and treatment compliance. Other recommendations included managing the resident's environment, utilizing behavior interventions for episodic behavior, and provide supportive encouragement to increase socialization. In an interview on 01/26/24 at 10:48 am, Unit Manager stated that since she was promoted into the Unit Manager in November 2023, Resident #2 refused care and was sometimes aggressive with staff, but he was doing well before his most recently reported incident on 01/14/24. Resident #2 was mild mannered and could sometimes be easy to redirect. The unit manager was not aware if Resident #2 had any behavioral ticks and stated that he was in a room without a roommate by chance and not for any specific reason. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 01/26/24 at 10:53 am, the Unit Manager stated that the facility staff did care plan meetings everyday where they discuss the needs of different residents with the social worker, nurse, and therapist if they were in therapy. The Unit Manager explained that she was responsible for making acute (day to day changes/trends) to the care plan, while each dept head had their own sections for updates. When asked when was the last care plan meeting she attended, she stated that she could not recall attending one for the year of 2024. She explained that the facility had changes in management, and they were working on getting all care plans updated. The Unit manager also stated that the importance of a comprehensive care plan was to outline the care that residents need and to give the floor staff a path for how they were to care for residents. In an interview on 01/26/24 at 11:12 am with CNA A, she stated that Resident #2 was aggressive and thought the facility was his house. Sometimes he would have good days, but he often would get upset or triggered when people would enter his room. She explained that in the past he would try and kick his roommates out, so Resident #2 was now housed in a private room. In an interview on 01/26/24 at 12:39 pm, MDS A stated that when she started at the facility in September 2023, that a lot of care plans had not been completed in some time due to a gap in employment. She explained that she implemented a PIP (performance improvement plan) that trained all staff in an attempt to get things back on track. She sent out daily reminders to alert staff on which care plans needed to be updated. MDS A explained that Resident #2's care plan had not been updated because he was sent out of the facility on 1/14/24 to a behavioral hospital and no one had signed or reviewed his plan of care. MDS A stated that the Unit Manager is responsible for updating the day-to-day changes in resident behaviors in the care plan. For quarterly care plans, MDS A stated that she liked to leave the care plan open for three months post the completion date so that each department head would have enough time to develop or revise the care plan. After the care plan had been revised, the social worker would reach out to the responsible party of the resident and schedule a care plan meeting in person or over the phone. MDS A explained that updates to the care plan are not her responsibility, but she was helping to get the facility up to date. Her priorities were MDS assessments, and she presented to the investigator her MDS assessments, which were last completed in November or December of 2023. In an interview on 01/26/24 at 3:38 pm with the Admin, she stated that she had been employed at the facility since December of 2023. She explained that she was aware that care plans were behind and that the facility had implemented a PIP to get back on track. The Unit Manger of each unit was responsible for updating the care plan with day-to-day changes while each department head was to update the other sections (activities, nursing, dietary, therapy). She explained that the harm in not having updated care plans was that staff would not have special instructions to handle the needs of each resident. Record review of the facility's policy titled Care Plans, Comprehensive Person- Centered, revised March 2022, displayed: a. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. b. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	c. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. d. The interdisciplinary team reviews and updates the care plan: 1. when there has been a significant change in the resident's condition; 2. when the desired outcome is not met; 3. when the resident has been readmitted to the facility from a hospital stay; and 4. at least quarterly, in conjunction with the required quarterly MDS assessment. f. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. This was determined to be an Immediate Threat (IT) on 02/14/24 at 10:45 am. The Admin and Corporate Nurse (CN) were notified. The Admin and Corporate Nurse (CN) were provided with the IT template on 2/14/24 at approximately 10:45 am. The following POR (Plan of removal) submitted by the facility was accepted on 02/16/24 at 01:45 pm. The POR documented: The facility failed: to supervise resident #3 from wandering into resident #2 rooms where she was injured and had to be sent to the hospital. Immediate action: resident #3 discharged to the hospital and resident #2 was sent to Oceans behavioral hospital for evaluation and treatment 1-14-2024. Resident #3 has been discharged not to return discharged on [DATE]. Resident #2 is stable and has not had any further behaviors went to Oceans Behavioral hospital on 1-14-24 and returned on 1-26-2024. Audit on the memory care unit initiated on 2-14-2024 by the in house MDS nurse. 30 residents reside on the memory care unit. The corporate MDS nurse came in on 2/15/2024 to assist with the audit process. All residents on the memory care unit have potential to wander. 13 out of 30 residents identified actively wander in the unit. The care plans for these 13 residents were reviewed and updated. 2/16/2024 Staffing Ratios were reviewed to ensure the facility has adequate staffing ratios. Staffing Ratios for the Memory Care Unit-3 aides 2 nurses and 1 activity staff on unit for increased supervision. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	This is the normal staffing pattern on the memory Care unit. o 6-2 (3 aides and 2 nurses 1 activity) o 2-10 (3 aides 2 nurses, activity leaves at 6pm) o 10-6 (one nurse and 2 aides) 2/15/2024 Regional MDS coordinator in facility to assist with identifying residents with wandering behaviors to ensure appropriate care planning is in place and accurate. 2/15/2024 Review of the SOM 689 accidents hazards/supervision/devices/with the Clinical team on 2/16/2024 at 0900 the department heads and the clinical team reviewed on the big screen TV the 689 regulation to validate 2-15-2024. This will be accomplished by reading the regulation in full and the critical pathway for Accidents will be reviewed verbally as a team. This will ensure that we have all the elements of training covered in the Pathway and additional training needed if necessary. Medical Director was notified on 2/14/2024 of IJ 689 Follow up with the medical director on 2/15/2024 @ 8:15am on IJ status. AD Hoc QAPI to be held 2/16/2024 with F-689 and SOC update on IJ reviews. An in-service initiated by the memory care RN, ADON - for increased monitoring of wandering residents, in the dining areas, and common areas and re-direction of the resident. All staff on 100-200-and 300 halls were in-serviced because the staff at any given moment could float to another unit. Central Supply and medical records assigned to assist with daily rounding in the unit until all walkie talkies are in place 2-14-2024 to 2-16-2024. New Weekend Supervisor starting on 2/17/2024 to provide supervisory coverage of the buildings on the weekends, 16-hour shifts. Both ladies are already assigned ambassadors to the memory care unit. They round before the morning meeting. After the morning meeting After Lunch And before they leave for the day Both offices are located in the same vicinity of the memory care unit. Walkie talkies (ordered on 2/15/2024) to be delivered on 2/16/2024: to be used by the aides and the nurses to communicate with each other. (continued on next page)

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F 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/15/24 a set of 12 long range rechargeable walkie talkies with batteries were purchased from an online vendor. On 02/16/24, walkie talkies arrived at the facility, were charged, and placed within the MC Unit. Record review of an in-service titled Supervision was started on 02/16/24. This in-service covered reasons why residents wander, hourly rounds on residents and management, redirecting residents who wander, and the use of walkie talkies on the MC Unit. Record review of Resident #2 monitoring sheets displayed that resident was checked every 30 minutes. No new behaviors or changes noted. Record review of newly hired RN weekend supervisor, start date 02/17/24. Sex offender registry, EMR, and license verification report completed. Monitoring Day 2: 02/17/24 Record review of an in-service titled Supervision was completed on 02/17/24. Sign in sheets showed a total of 80 staff who provide direct care or nursing services. In an interview with CNA F on 02/17/24 at 5:30pm, she stated that she worked the 10pm- 6am shift. She was informed on how to use the walkie and the purpose was for staff to be able to monitor residents in the MC Unit who may wander. She explained that sometimes residents will wander because they are looking for family and you may be able to help with a phone call. If a resident is aggressive with another resident, she will intervene to ensure the safety of that resident. If a resident is showing aggression towards herself, she would walk away and reapproach later. In an interview with CNA G on 02/17/24 at 5:35 pm, she stated that she worked the 6pm-2am shift. She explained that a resident may wander because of hunger, or they may need to be changed. If she witnessed this behavior, she would try to redirect them or offer them a snack. She stated she normally worked on a hall without wandering residents, so if she noticed this behavior, she would chart it in PCC and immediately inform her charge nurse. In an interview with CNA H on 02/17/24 at 5:39 pm, she stated that she worked the 2pm- 10pm shift and that she was told to redirect and offer snacks to residents who wander. It was important to know where residents are at all times and wanderers have a wander band that goes off when they come too close the door. If she had a resident that started to walk around aimlessly, she would try to toilet them, offer snacks, and let her charge nurse know. Then she would chart it in PCC. In an interview with LVN B on 02/17/24 at 5:47 pm, she stated that she worked the 6am- 2pm shift. She explained that in the in-service, they talked about the locked unit and that staff was responsible to do checks on residents. They must have a person supervising the MC Unit and they will use the walkies to alert other people that the resident was walking around. The walkie talkies help staff better communicate with each other. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675789	A. Building B. Wing	02/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Wood	8810 Long Point Dr 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 0657 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with CNA I on 02/17/24 at 5:53 pm, she stated that she worked the 10pm- 6am shift. She explained that she normally worked the 10pm-2am shift. In the in-services given, she was informed that if she saw a resident wandering, she was to redirect and see if she could meet their needs. She explained that if she noticed a resident on her unit (non MC hall) began to wonder, she would tell her charge nurse immediately of the unusual behavior and chart it in the kiosk. In an interview with LVN C on 02/17/24 at 6:07 pm, she stated that she is a nurse in the MC unit who normally worked the 2pm-10pm shift. She stated that in the in-services, she was taught to redirect all residents who are seen wandering by offering them snacks, toileting, redirection, and assessing pain levels. In an interview with RN A on 02/15/24 at 6:12 pm, he stated that he worked the 2pm to 10pm shift. He explained that if staff saw somebody wondering, they investigate why, and see if they are hungry or want to be changed. Staff will check the diapers to see if they are wet, offer food and snacks, see if they are looking for someone to talk to, or try to find out what they want. The unit was given walkies that work by pushing the side button and talking. MC staff know that his cart is in front of the nurse's station on the MC Unit. If he left to go to another area, MC staff can walkie him. If the aid in the dining area saw a resident in the front room leaving out, all MC staff must acknowledge that that can hear the staff letting them know a resident was on the move and to keep eyes on them. In an interview with LVN D on 02/17/24 at 6:45 pm, she stated that she worked the 6am- 10:30pm shift on Saturday and Sundays. She stated that in the in-service given on 2/16/24, her takeaways were that wandering behaviors in a resident may be related to an underlying factor. Staff should check and see if they resident needs to be changed, offer snacks, monitor their whereabouts, then redirect them. She also explained that the behavior could also be as simple as the resident looking for someone to talk to. She also stated that the MC unit had walkie talkies now, which will help staff communicate on where the residents are and what they may need. In an interview with CNA J on 02/17/24 at 6:50 pm, she stated that she worked the 2pm-10pm shift. She was in serviced on residents who wander and informed to redirect them when this behavior is noticed. She explained that if a resident fights, staff should separate them and try to see if they would like to participate in an activity or if they would like a snack. Immediately after, this behavior should be reported to the nurse and updated on the Kardex in PCC. The Corporate Nurse was informed the Immediate Jeopardy (IJ) was removed on 02/17/24 at 7:00 pm. The facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that was not an Immediate Jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.