

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Birchwood of Golfcrest		STREET ADDRESS, CITY, STATE, ZIP CODE  7633 Bellfort Houston, TX 77061	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215</b></p> <p>Based on observation, interviews, and record reviews, the facility failed to ensure each resident was free from abuse and neglect for 1 (Resident #2) of 12 residents reviewed for abuse and neglect.</p> <p>-The facility failed to ensure that Resident #1 was free from mental abuse when CNA B yelled at him and used a racial slur during his nephrology appointment at the hospital.</p> <p>This failure could place residents at risk of serious harm that has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.</p> <p>Findings included:</p> <p>Record review of the face sheet for Resident #2 dated 08/01/2024 revealed a [AGE] year-old male admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), obesity (a disorder that involves having too much body fat, which increases the risk of health problems), type 2 diabetes mellitus (a long term condition in which the body has trouble controlling blood sugar and using it for energy, and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).</p> <p>Record Review of Resident #2's Annual MDS assessment dated [DATE] revealed a BIMS score 12 out of 15, indicating residents' cognition had mild impairment. Further record review revealed he was dependent for toileting, shower/bath, lower body dressing, putting on/taking off footwear and personal hygiene. He required substantial maximum assistance for upper body dressing and set-up or clean up assistance for eating. He did not walk and used a manual wheelchair for mobility. He was dependent on chair to bed transfer and needed partial/moderate assistance to roll left and right.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan dated 7/1/2024 revealed, Focus: diabetes mellitus, Goal: Resident #1 will have no complications related to diabetes through the review date. Date Initiated: 03/01/2023 revision on: 01/02/2024 Target date: 06/07/2024, and intervention: Check all of body for breaks in skin and treat promptly as ordered by doctor. Date Initiated: 03/01/2023. Revision on: 03/01/2023, diabetes medication as ordered by doctor, monitor/document for side effects and effectiveness. Date Initiated: 03/01/2023, revision on: 03/01/2023 dietary consult for nutritional regimen and ongoing monitoring.</p> <p>Observation and interview on 7/31/2024 at 4:31p.m., with Resident #2 revealed him sitting in his wheelchair at the dining table. He said he was doing well and did not have too many concerns. He said he had only one issue with a staff member. He said there was a staff member that called him the N word. He said he was not sure why she called him that name. He said he did not know her name, but she is still working at the facility. He said she is an African American female. He said she was never physical with him. He said he did not have any problems with other staff members.</p> <p>Interview on 8/1/2024 at 12:54p.m., with CNA B she said she accompanied Resident #2 on 4/4/2024 to the hospital. She said that day she worked from 6:00a.m. to 2:00p.m. She said when the scheduler found out about the appointment, and although she was soon to be off at 2p.m., she was available to go out with Resident #2. She said she was not the driver. She said she sat in the back of the van with Resident #1. She said he was the only resident for that appointment at that time. She said when she arrived at the doctor's appointment, she stayed with Resident #2 the entire time. She said she did not leave him by himself. She said she never fell asleep while accompanying Resident #2. She said she was never disrespectful to Resident #2, and she did not call him a nigger. She said Resident #2 was easy to work with. She said there were no mean or hurtful words exchanged between her and Resident #2 on that day. She said she cannot recall the time Resident #2 was picked up. She said she knew the doctor's office was closing. She said they were late being picked up due to the driver having to drop a resident off at the facility. She said she called to see how far the driver was to let them know the clinic was going to close. She said she did not go back and forth with Resident #2. She said she never had any issue with any of the residents at the facility. She said there was a lady at the hospital who was rude to Resident #2, but it was not her.</p> <p>Follow-up observation and interview on 8/1/2024 at 1:08p.m., with Resident #2 revealed him sitting in his wheelchair playing on his cellular phone. He said he did not tell anyone about what CNA B said to him. He said he did not know why he did not say anything to anyone. He said he just didn't tell anyone. He said when CNA B called him the N word, it did not make him feel good. He said he had not had any other incidents with CNA B. He said he was not sure why the bus was late, but they were late picking him up from his appointment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 8/9/2024 at 11:43a.m., with the Patient Affairs Specialist and she said Resident #2 came for a nephrology (is a specialty for both adult internal medicine and pediatric that concerns the study of kidneys, specifically normal kidney function, kidney disease, the preservation of kidney health, and treatment of kidney disease, from diet medication to renal replacement therapy) appointment. She said CNA B was with him. She said CNA B was very rude from the very beginning. She said she thought CNA B was a family member accompanying Resident #2. She said the provider asked Resident #2 how old he was, and he replied, 54. She said CNA B said in an aggressive way, Nigger you are not 54, you are 53. Don't you be lying. She said Resident #2 was quiet after that happened and shut down. She said she called the facility to talk to the Administrator, the Don, and the Social Worker but whoever answered the phone was extremely rude to her and no one called back. She said CNA B disappeared for two hours. She said no one could find her and Resident #2 was not picked up until 6:45p.m. She said the clinic closed at 5:00p.m. She said CNA B was sleeping, and she also put her fingers in her supervisor's face when they were advocating for Resident #2 to be picked up. She said she was glad there was a third person in the van with Resident #2 and he was not left alone with CNA B.</p> <p>Record review of the facility's policy titled Abuse Prohibition Standard of Practice review date on (10/2020) read in part . each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The resident has the right to be free from mistreatment, neglect, and misappropriation of property. The following standards of practice will be operationalized in order that residents will not be subject to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. The Facility shall ensure that all alleged violations are reported immediately to the administrator or the administrator's designee. Local law enforcement, the state survey agency, and the Department of Family and Protective Services (if appropriate) will be notified in accordance with federal and state law. Any reasonable suspicion of a crime against a resident will be reported to appropriate law enforcement no later than 2 hours of forming the suspicion .</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47215</p> <p>Based on interview and record review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort for 1 of 12 residents (Resident #1) reviewed for PASARR in that:</p> <ul style="list-style-type: none"> <li>- Resident #1 did not have a PASARR assessment completed within 20 days of admission.</li> </ul> <p>This failure could place newly admitted residents at risk of not receiving services to meet their needs.</p> <p>Findings Include:</p> <p>Record review of Resident #1's Face sheet revealed a [AGE] year-old female who admitted to the facility on [DATE] with the following diagnoses, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), cognitive communication (trouble reasoning and making decisions while communicating), moderate intellectual disabilities (observable development delays, which may be accompanied by physical impairments), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), essential hypertension (a form of hypertension without an identifiable physiologic cause), and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors).</p> <p>Record review on Resident #1's Admission MDS assessment dated [DATE], revealed he had a BIMS score of 10 out of 15, indicating she had moderate cognitive impairments. Further record review revealed she was dependent for toileting, shower/bath, upper body, lower body dressing and personal hygiene. She required partial/moderate assistance for oral hygiene and setup or clean-up assistance for eating. She did not walk and used a manual wheelchair for mobility. He was dependent on chair to bed transfer and needed partial/moderate assistance to roll left and right.</p> <p>Record review on of Resident #1's Baseline Plan of Care dated Admission: 6/12/2024, Focus, Goal and interventions were blank. There was no initiated date or revision date for PASARR.</p> <p>Record review of Resident #1's PASARR Level 1 Screening, revealed Date of assessment 06/20/2023 completed by the Social Worker, revealed; C0200 intellectual disability: Is there evidence or an indicator this is an individual that has intellectual disability? Yes.</p> <p>Record review of Resident #1's Pre-Admission Screening and Resident Review (PASARR) Evaluation Summary Report revealed date of PASARR evaluation 6/21/2023. PASARR qualifying diagnosis: intellectual developmental disability. Recommended Nursing Facility specialized service (IDD only): physical therapy (PT), occupational therapy (PT), specialized Assessment Physical Therapy (PT), specialized Assessment Occupational Therapy (OT).</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 8/1/2024 at 1:34p.m., with the Social Worker and she said the MDS Coordinator and herself were responsible for the PASARR assessment. She said since she had been at the facility the longest and would like to keep the PASARR assessment stable and consistent, she would complete the applications. She said when the applications were accepted by the mental health facility, she would receive an email from the mental health facility letting her know who was going to do the assessment. She said if the resident was marked positive, someone from the mental health facility would come out do assessment and speak with the resident. She said she would meet with the IDT team and schedule the initial meeting. She said the PASARR was supposed to be completed the first week the resident arrived at the facility. She said Resident #1's initial PASARR was completed on 6/20/2023. She said Resident #1 was admitted to the facility on [DATE]. She said she was sick with the flu and there was no one at the facility to complete the PASARR assessment. She said the PASARR was supposed to be completed within the first 20 days of their admission and it did not happen. She said it was important to have the PASARR done so they could continue their services. She said if the PASARR assessment was not completed in a timely manner, the resident could miss out on services and therapy that they could possibly need.</p> <p>Interview on 8/1/2024 1:55p.m., with the MDS Coordinator A and said she had been at the facility for only a month. She said now, as soon as she received the PASARR, she would put them into the system properly. She said the Social Worker had been working to put in their PO1's. She said the social worker would provide the information to the IDT team during their quarterly meetings. She said she would make sure the staff was aware of the PASSAR status. She said it was important for the PASARR assessment to be completed within 20 days, to establish whether the resident had a positive screening, had a mental illness, intellectual disabilities, in need of mental health services and to customize their care plan to meet their needs. She said if the PASARR was not completed, the facility would fail to properly identify the resident's needs. She said the facility was not in compliance with the PASARR assessment for Resident #1 if she was admitted on [DATE] and it was completed on 6/20/2023.</p> <p>Interview 8/1/2024 2:03p.m., with MDS Coordinator B, and she said she was responsible for being a part of the PASARR quarterly and annual meetings. She said she enters a form into the computer that is filled out regarding the PASARR assessments. She said the initial PASARR was completed by the Social Worker. She said if the PASARR assessment was completed on 6/20/23, it would be within time frame it was supposed to be completed. She said she was not working at the facility during that time. She said she came to work at the facility on 11/1/2023. She said if the PASARR assessment was not completed in a timely manner, Resident #1 would not have the services they were entitled to receive and need.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of the facility's Handbook titled revised on dated 7/7/2019 read in part . Preadmission screening and resident review (PASRR) is a federal requirement documented in the Code of Federal Regulations, Title 42, Part 483, Subpart C. PASRR is a process to identify people with a mental illness (MI), intellectual disability (ID), or developmental disability (DD), which is also known as a related condition (RC), who apply to, or reside in, a Medicaid-certified nursing facility (NF) to ensure that NF admission is appropriate. PASRR is also intended to ensure that people with MI, ID or DD are receiving all the necessary specialized services. In Texas, local intellectual and developmental disability authorities (LIDDAs), local mental health authorities (LMHAs) and local behavioral health authorities (LBHAs) play key roles in the PASRR process. Texas Health and Human Services Commission (HHSC) rules governing PASRR are in 26 Texas Administrative Code (TAC) Chapter 303, for LIDDAs, LMHAs and LBHAs and 26 TAC Chapter 554, Subchapter BB, for NFs. This handbook provides additional instructions and procedures for LIDDAs in implementing PASRR requirements. This section provides an overview of the PLI Screening and its role in the PASRR process. The PLI Screening. Form may be downloaded from the Texas Medicaid &amp; Healthcare Partnership_(TMHP). 2310 Purpose Revision 22-1; Effective Nov. 28, 2022, The PLI Screening form is designed to identify people suspected of having an MI, ID, or DD who are seeking admission to a NF. The PLI screens for possible eligibility for PASRR specialized services and is the [NAME] step toward enabling people to be served per their unique needs. 2320 PLI Screening Form Revision 22-1; Effective Nov. 28, 2022, .</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 1 of 12 residents (Resident #1) reviewed for PASRR assessments.</p> <p>-The facility failed to ensure Resident #1 who had a diagnosis of major depressive disorder, and intellectual disability, had an accurate PASSR Level I assessment or received a PASRR Level II assessment or evaluation.</p> <p>- Resident #1 did not have a PASARR assessment completed within 20 days of admission.</p> <p>This failure could place residents with a serious mental illness at risk of not receiving needed care and services to meet their individual needs.</p> <p>Findings Include:</p> <p>Record review of Resident #1's Face sheet revealed a [AGE] year-old female who admitted to the facility on [DATE] with the following diagnoses, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), cognitive communication (trouble reasoning and making decisions while communicating), moderate intellectual disabilities (observable development delays, which may be accompanied by physical impairments), post-traumatic stress disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event), essential hypertension (a form of hypertension without an identifiable physiologic cause), and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors).</p> <p>Record review on Resident #1's Admission MDS assessment dated [DATE], revealed he had a BIMS score of 10 out of 15, indicating she had moderate cognitive impairments. Further record review revealed she was dependent for toileting, shower/bath, upper body, lower body dressing and personal hygiene. She required partial/moderate assistance for oral hygiene and setup or clean-up assistance for eating. She did not walk and used a manual wheelchair for mobility. He was dependent on chair to bed transfer and needed partial/moderate assistance to roll left and right.</p> <p>Record review on of Resident #1's Baseline Plan of Care dated Admission: 6/12/2024, Focus, Goal and interventions were blank. There was no initiated date or revision date for PASARR.</p> <p>Record review of Resident #1's PASARR Level 1 Screening, revealed Date of assessment 06/20/2023 completed by the Social Worker, revealed; C0200 intellectual disability: Is there evidence or an indicator this is an individual that has intellectual disability? Yes.</p> <p>Record review of Resident #1's Pre-Admission Screening and Resident Review (PASARR) Evaluation Summary Report revealed date of PASARR evaluation 6/21/2023. PASARR qualifying diagnosis: intellectual developmental disability. Recommended Nursing Facility specialized service (IDD only): physical therapy (PT), occupational therapy (PT), specialized Assessment Physical Therapy (PT), specialized Assessment Occupational Therapy (OT).</p> <p>(continued on next page)</p>		

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