STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676021	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarewood House Extended Care Center	7400 Clarewood Dr Houston, TX 77036

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45581 Based on record review and interviews, the facility failed to provide the contact information of the practitioner responsible for the care of the resident; the resident representative information including contact information; the advance directive information; all special instructions or precautions for ongoing care, as appropriate; and comprehensive care plan goals for 1 of 3 residents (Resident #18's) reviewed for closed records reviewed for an effective discharge process. The facility failed to ensure Resident #18's, who was discharged on [DATE], discharge summary was complete. This failure could affect residents who are discharged from the facility by not ensuring that care is coordinated and the resident transitions safely from one setting to another in addition to helping reduce or eliminate confusion among the various facilities, agencies, practitioners, and caregivers involved with the resident's care. Findings included: Record review of Resident #18's Face Sheet (undated) revealed, a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included: Saddle embolus of pulmonary artery (large blood clot that sits atop or saddles the main pulmonary artery where it divides and branches into the left and right lungs) with acute pulmonale (symptoms can include shortness of breath, bulging veins in your neck, swelling in your legs or belly, fatigue, chest pain, and fainting episodes.) (Primary, Admission), Chronic obstructive pulmonary disease (common lung disease causing restricted airflow and breathing problems.), unspecified. Resident #18 was discharged on [DATE]. Record review of CR#1's Discharge MDS assessment dated [DATE] revealed a BIMS score of 10 out of 15 indicating moderate mental deficit. Further review of Section X0600. Types of Assessment: F. Entry/discharge reporting coded was blank. Section A2105. Discharge Status was coded- 06- Inpatient Rehabilitation Facility. Record review of Resident #18's Care Plan initiated 06/22/2024 and updated on 07/02/2024 read in part . (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Problem: Modified Independence R/T BIMS Score of 10/15. Goal: Will reduce risk of complications over next 90 days. Approach: Allow extra time to collect & process thoughts. Assist to needed locations QD. Assess psycho/social needs prn. Break down activities in manageable segments. Encourage to participate in activities. Talk to resident during care explain procedures. Provide cueing & redirection prn. Provide supervision & assist /c ADLS prn. Provide consistent & routine environment QD. Problem: Decline in ADL function R/t BL Extremity weakness and unsteady gait, need extensive assistance from 1-2 person for transfer and 1 person for ADL care. Goal: Will reduce risk of complications over next 90 days. Approach: Assist /c all ADLS x aide QD prn. Staff to gather supplies, shampoo hair, bathe, oral & nail care per schedule & prn. Offer choices for what to wear. Provide assist to stand & transfer to bed/chair x 1-2 aide QD prn. Monitor for incontinence Q2hrs & prn. Assist to toilet Q2hrs & prn. Set up meal tray, open cartons, cut meat prn. Explain all procedures using terms & gestures resident can understand. Be patient & allow time to complete tasks. Provide Foley catheter care as needed, PT/OT if needed . Record review of Resident #18's Discharge Summary dated 07/15/2024 noted there was no contact information of the practitioner responsible for the care of the resident; the resident representative information including contact information; the advance directive information; all special instructions or precautions for ongoing care, as appropriate; and comprehensive care plan goals. Record review of an undated blank Post Discharge Plan of Care: Nursing Services given to me by the Social Worker to show what should have been in Resident #18's chart noted a place for the facility name, phone number, address, reason for discharge, nursing needs, personal needs, Level of assistance required with ADLs, and Level of assistance required with IADLs. There was no space for Advance Directives. Record review of Discharge Summary and Plan dated October 2022 read in part . When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge. 4. The post-discharge plan is developed by the care planning/interdisciplinary team with the assistance of the resident and his or her family and includes: a. where the individual plans to reside; b. arrangements that have been made for follow-up care and services; 12. A copy of the following is provided to the resident and receiving facility and a copy will be filed in the resident's medical records: a. An evaluation of the resident's discharge needs; b. The post-discharge plan; and c. The discharge summary. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/12/2024 at 1:57 PM with the Social Worker revealed she was responsible for resident discharge planning. She said the ADON and herself were responsible for the Discharge Summary. She said she would look at the Progress notes to look for the date of discharge. She said the previous social worker may have forgotten to make a copy of the Discharge Summary. She said she was not sure what his admission status was and was not sure why he was discharged . She said she thought it may have been the resident's decision to discharge from the facility. She said the ADON might know why he was discharged . She said it was her 4th day at the facility. She said her role at the facility was as the social worker was to participate in Care Plan meetings, and discharge planning, and weekly Medicare meetings. She said she was not familiar with Resident #18. She said the policy or procedure for discharge planning was to meet with resident and or family members within 48 hours of admission and ensured everyone knew what the plan was and agreed to it, set up home health, ensured the resident had the proper equipment and she coordinated with therapy on that. She said the information that was required on discharge summary was things like home health or rehab, what equipment and where it was from, community resources, who was doing housekeeping, social support system, who their PCP and pharmacy were as well as their transportation needs, the discharge location, a contact, and the reason for discharge. She said she made 3-4 follow up calls after a discharge, but if the resident was going to another facility she would not make follow up calls. The follow up calls were only if residents were going back home. She said she had training on discharge planning when she previously worked at the facility. She said she would guess the DON or ADON were responsible for oversight to ensure staff was following protocol. She said the risk to residents if policy or procedures were not followed would be residents may not have their needs fully met once they were at their discharge location. She said the worst thing that could happen to a resident if policy or procedures were not followed was the resident may have access to things that would facilitate them to remain in their home. Interview on 09/12/2024 at 2:05 PM with the Rehab Director revealed the resident was always planned to go to another facility from the hospital and stay a while. She said Resident #18 and the family initiated the discharge. He was not set to leave when originally planned and the resident left earlier than what the facility had scheduled . She said Resident #18 was planned to discharge in a week, but the family came to get the resident 3 days later. Interview on 09/12/2024 at 2:011 PM with the LVN-ADON revealed she said when a resident left a facility, it was because they met skilled requirements. She said the social worker wrote the discharge summary. She said she was not aware of a Discharge Summary document. She was shown a copy of the Plan of Discharge document and she said the charge nurse should write the nursing part of the discharge. She said she had worked at the facility for 5 years in January. She said part of her role was to complete the Post Discharge Plan of Care. She said she was familiar with Resident #18. She said the policy or procedure for discharge summaries/discharge planning was the social worker initiated the Post Discharge Plan of Care and she the ADON completed the nursing part of it including diet. She did not know what the Discharge Summary was incomplete. She said she had not been in-serviced on that before. She said the resident left unexpectedly before she could complete it. She said the social worker was responsible for ensuring the Discharge Plan of Care was complete. She said there was no risk to residents if policy or procedure was not followed. She said staff provided patient teaching, the medication list, and the residents knew who their doctors were. She said there really was no risk. Interview on 09/12/2024 2:16 PM with Medical Records revealed the resident's family member talked about the resident going to another facility, but did not know when he would be going. When the resident left the family just took him without letting them complete the form. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/12/2024 at 2:56 PM with the DON said the family was unsure the resident could transfer to the another facility and the facility was caught off guard when the family came to take him to the other facility. Interview on 09/12/2024 at 3:07 with the Administrator revealed he said, with discharge planning, the social worker was in charge of that. He said the Discharge Summary was supposed to have where they were going, what medications they were on, what equipment they needed, did they need home health, what supplies they would need, and whether to continue the care. He said the facility ensured where they were going was appropriate , and they called and followed up a week later to check on them. He said he had worked at the facility for [AGE] years and his role at the facility was Executive Director and Administrator. He said he was not familiar with Resident #18. He said, routinely, he ensured the facility stayed in compliance, attended standup meetings, tracked who was being discharged , talked with residents and visited with them, asked how things were going, assisted with ensuring staffing was in place, stood in on all the committees, ensured staff were there and doing their jobs, talked with staff about residents, reviewed incident/accidents, met with all directors, and communicated with families. He said the discharge plan should start as soon as possible. He said the facility needed to determine if a resident was short-term or long-term, ensured their needs were being meet, coordinated with family to get with all outside agencies, ensured the orders were sent, and got the NOMNCs signed. He said he did not know what happened with Resident #18. He said the former social worker was sick and not doing well. He said she had to resign. He said generally the social worker communicated with the team, but as Administrator he knew who was going and coming. The primary staff responsible for ensuring policy/protocol was followed, would be the social worker. He said the risk to residents if policy or protocol was not followed depended on the resident and what needs they had; their needs might not be met. He said the worst thing that can happen to the resident when proper protocols were not practiced was it could result in a lack of needed services.