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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676194	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mason Creek Transitional Care of Katy	21727 Provincial Blvd Katy, TX 77450

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 - Few	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** 36918 Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 of 4 residents (Resident #1) reviewed for resident abuse. The facility failed to prevent Resident #1 from being physically abused by LVN B on 12/05/23. The noncompliance was identified as past noncompliance (PNC) IJ. The noncompliance began on 12/05/23 and ended on 12/12/23. The facility corrected the noncompliance before the survey began. This failure could place residents at risk of physical harm, mental anguish, and/or emotional distress. Findings included: Record review of Resident #1's face sheet dated 09/25/24 revealed an [AGE] year-old female admitted to the facility initially on 11/09/21 and readmitted [DATE]. Resident #1 had diagnoses which included Major depressive disorder (mental health condition that cause loss of interest in activities that once brought joy), dementia (impair ability to remember, think, or make decisions that interferes with doing everyday activities), and anxiety disorder (excessive worry and feelings of fear, dread, and uneasiness). Record review of Resident #1's quarterly MDS assessment, dated 09/09/2024, revealed a BIMS score of 02 out of 15, which indicated the resident's cognition was severely impaired. Further review of Resident #2's MDS revealed the resident needed extensive assistance with ADL care. Record review of Resident #1's undated care plan initiated 11/09/21 revealed: Resident #1 had impaired cognitive function or impaired thought processes related to Dx of Dementia. An intervention included: Communication: Identify yourself at each interaction, face when speaking and make eye contact, use simple, directive sentences, provide with necessary cues- stop and return if agitated. Observation and interview on 09/24/24 at 11:20 a.m., Resident #1 was in bed, and she was dressed in her street clothes. Resident #1 was not able to say if the staff was abusive to her. Resident #1 was a poor historian. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/24/24 at 1:40 a.m., ADON A said there was an issue on 12/04/23 with LVN B when Resident #1 bumped into LVN B while she stood by the medication cart in front of the nursing station. ADON A said LVN B turned around and pushed Resident #1's wheelchair away and leaned forward in front of Resident #1 while she talked to Resident #1 aggressively, but there was no audio. ADON A said LVN B slapped Resident #1's hand away when Resident #1 raised her hand. ADON A said there was no reason for LVN B to physically abuse Resident #1. During an interview on 09/24/24 between 10:47 a.m. and 5:54 p.m., (2 LVN, 1 CNA, 1 MA, 1 shower teach) from day shift were interviewed on the facility in service on abuse/neglect. All staff interviewed were able to verbalize understanding of abuse/neglect in-services received. During an interview on 09/25/24 at 11:35 a.m., the DON said while she was making rounds on 12/05/23, a resident told her she heard loud noise last night (12/05/23). The DON said she reviewed the facility camera and saw LVN B standing in front of the medication cart by the nursing station when Resident#1 bumped into LVNA B. The DON said LVN B shoved Resident #1's wheelchair back forcefully, leaned forward to Resident #1, and pointed to Resident#1's face, but she could not hear what she said because the camera had no audio. The DON said LVN B's demeanor was intimidating, and it made her the DON sick. The DON said the video of the incident was not available to be reviewed when surveyors entered. The DON said she immediately reported it to HHSC. The DON said she called LVN B at home and told LVN B she could not return to the facility because of the incident, and LVN B was terminated after the facility investigation, which indicated LVN B abused Resident #1. During an interview on 09/25/24 at 11:43 a.m., the DON said they had QAPI about the incident, in-service with the staff on abuse/neglect, they did safe survey with residents, and the DON would train new staff upon hire on abuse/neglect. During an interview on 09/24/24 between 12:7 a.m. and 3:25 p.m., (3 LVN, and 1 CNA) from day shift were interviewed on the facility in service on abuse/neglect. All staff interviewed were able to verbalize understanding of abuse/neglect in-services received. Record review of the provider investigation report dated 12/05/23 revealed LVN B written statement reflected, I would never treat my patients in such a way. I was doing my job at the nurse's cart when the resident approached me demanding coffee. I told her that the kitchen was closed for the day, and she continued to try and roll past me. When she did, she ran into my foot and by reaction, I moved her continued to try and roll past me. When she did, she ran into my foot and by reaction, I moved her chair away to prevent injury to myself. I then attempted to redirect the resident by getting eye level with her and gestured to her, the kitchen is closed. She then attempted to hit me, so I attempted to block her from injuring me . the facility investigation reflected the incident happened on 12/5/23, and abuse was substantiated . Director of Nursing viewed security footage from around 7pm the night prior and noted an interaction between Resident #1 and LVN B. Footage revealed that Resident #1 was in her wheelchair rolling slowly towards the dining room. She stopped shortly next to LVN B at her nursing cart, at the nurse's station. Resident#1 then proceeded to propel herself slowly bumping LVN B's foot. In response, LVN B forcefully pushed Resident #1's wheelchair backwards and proceeded to point her finger at Resident #1. Verbal interaction took place between Resident #1 and LVN B. Resident #1 appeared to start yelling at the nurse and in return LVN B (continued on next page)

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