Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676194	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on observation, interview, and interview, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 9 residents (CR #1) reviewed for change of condition. The facility failed to notify CR #1's physician or seek medical guidance when he experienced a drop in oxygen saturation during physical therapy just after breakfast on [DATE]. At approximately 3:00 p.m., CR #1 experienced a drastic desaturation (a decrease in oxygen saturation, low blood oxygen concentration) to 53% after a shower and resulted in loss of consciousness, initiation of CPR, and intubation (a medical procedure that involves inserting a flexible tube into the trachea to help maintain an open airway). CR #1 expired on [DATE] on hospice at his home. An IJ was identified on [DATE] at 2:52 p.m The IJ template was provided to the facility on [DATE] at 2:52 p. m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the severity level at a potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on [DATE]. This failure placed residents who experience a change of condition at risk of worsening of condition and possible death. Findings include: Record review of CR #1's face sheet, dated [DATE] revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] from an acute care hospital. He was diagnosed with UTI (an illness in any part of the urinary tract), diabetes mellitus type 2 (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), aphasia (a language disorder that affects a person's ability to communicate), acute and chronic respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues in your body [hypoxia] or when there is too much carbon dioxide in your body. It can happen all at once [acute] or come on over time [chronic]), and essential hypertension (a form of hypertension without an identifiable cause). CR #1 was discharged to an acute care hospital on [DATE]. Record review of CR #1's MDS dated [DATE] revealed he was admitted from an acute care hospital on [DATE]. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's BIMS dated [DATE] at 2:55 p.m. revealed he had a score of 0 (severe cognitive impairment). Record review of CR #1's Functional Abilities Admission assessment dated [DATE] revealed, MDS Reason for Evaluation: Admission/5-Day . Self-Care: Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury - Independent - Resident completed all the activities by themselves, with or without an assistive device, with no assistance from a helper . Prior Device Ise - Manual Wheelchair, [NAME] . Record review of CR #1's care plan dated [DATE] revealed the following care area: * ADL Self Care Performance Deficit. Goal included: Will safely perform bed mobility, transfers, eating, dressing, grooming, toilet use, and personal hygiene with modified independence. Interventions included: Occupational, Physical, Speech-Language Therapy evaluation and treatment per physician orders; Toilet Use: requires assistance; Transfers (Chair /Bed to Chair Transfer, toilet transfers: Requires staff participation with transfers; Bed Mobility: Requires staff participation to reposition and turn in bed; Encourage to participate to the fullest extent possible with each interaction; Bathing (Shower/Bathe Self): Staff will provide the required assistance needed for bathing; Personal Hygiene/Oral care: Staff will provide the required assistance needed for personal hygiene/oral care; Dressing: Requires staff participation to dress; Eating: Staff will provide the required assistance needed for eating as needed. Further review of CR #1's care plan revealed no focus/care area related to his respiratory condition or oxygen requirements/needs. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's preadmission hospital records dated [DATE] revealed he was admitted to a local acute care hospital on [DATE] for weakness and was diagnosed with complicated UTI (any UTI that is not considered simple, and defined by the presence of underlying conditions rather than the severity of the infection), acute on chronic respiratory failure with hypoxia, acute toxic metabolic encephalopathy (a condition that causes global cerebral dysfunction, resulting in altered consciousness, behavior changes, and seizures), acute diarrhea due to E.coli (diarrhea caused by bacteria), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), pulmonary fibrosis (a condition in which the lungs become scarred over time), acute on chronic congestive heart failure (a type of heart failure that occurs when the heart has difficulty compensating for a loss of function that has developed over time) and history of CVA (a stroke; when blood flow to the brain is suddenly cut off) with global aphasia (a severe form of non-fluent aphasia caused by damage to the left side of the brain). The document read in part, . [CR #1] is a [AGE] year-old male with pulmonary fibrosis who was hospitalized for metabolic encephalopathy and atrial fibrillation with rapid ventricular response due to complicated UTI and infectious diarrhea. Patient improved with supportive measures including antibiotics and rate control. Patient was discharged in stable cardiology and pulmonology for continued evaluation and management as outpatient . Review of Systems . Respiratory: Negative for cough, shortness of breath, and wheezing . Respiratory/Pulmonary Interventions Documentation: . Respiratory Quality/Sounds: Dyspnea (shortness of breath) on exertion, dyspnea laying flat, dyspneic (having difficulty breathing or being unable to breathe without effort), tachypneic (fast breathing) . Respiratory/Pulmonary Interventions: O2 Delivery Method: Nasal cannula; O2 flow rate (L/min): 5 L/min . [DATE] . History of Present Illness . He was on baseline O2 of ,d+[DATE] L/min . Patient was admitted for further evaluation . He developed episode of a-fib and SOB/cough overnight, given breathing treatments and IV metoprolol (a medication used to treat high blood pressure, chest pain, and heart failure) . Currently he is resting in bed, no acute distress. On 6L/min via nasal cannula . Pulmonary and Critical Care Consult Note, [DATE]. Assessment: Chronic hypoxic respiratory failure with home oxygen dependence between 4 to 6 L/min at baseline, 8L with exertion . Pulmonary Progress Note: [DATE] . Patient states his breathing feels comfortable at his baseline oxygen requirement of 5L/min . He has been saturating at 100% . Record review of CR #1's Initial Admission Record dated [DATE] revealed LVN C wrote . Most Recent O2 saturation: 98% ([DATE] at 5:15 p.m.) Method: oxygen via nasal [cannula] . General Skin Condition: Normal - Yes, Pale/Ashen - No, Flushed - No, Cyanotic (bluish or purple discoloration) - No . Pulmonary System. Diagnosis: Does the Resident have a Pulmonary Diagnosis - No . Pulmonary System. Oxygen. Oxygen Use - No . Record review of CR #1's physician's orders for [DATE] revealed: * Check and record O2 Saturation every shift. Order Date: [DATE]. Start Date: [DATE]. * O2 at ,d+[DATE] L/Min Continuous per nasal cannula every shift. Order Date: [DATE]. Start Date: [DATE] Record review of CR #1's MAR for [DATE] (there was no MAR for [DATE]) revealed: * Check and record O2 Saturation every shift. There were no entries for this order. CR #1 was hospitalized . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* O2 at ,d+[DATE] L/Min Continuous per nasal cannula every shift. There were no entries for this order. CR #1 was hospitalized . Record review of CR #1's progress notes for [DATE] revealed: On [DATE], LVN D wrote, At 5:15 p.m., patient arrived as a new admit to the facility via wheelchair with belongings . O2: 98% 5L of O2. NP notified of admit and verified orders and lab orders for CBC and BMP. Record review of CR #1's progress notes for [DATE] revealed: * On [DATE] at 1:57 p.m., LVN E wrote, COC for CO2 of 45 (normal range 21.0 - 31.0). Resident has a critical lab of CO2 45, NP informed and awaiting new orders. * On [DATE] at 6:08 p.m., LVN E wrote, Resident had just finished taking a shower when the CNA [CNA B] brought out the resident from the bathroom looking weak but breathing. This nurse told the CNA to take resident back to his room. Later this nurse was called by CNA that resident is not looking good. This nurse did a sternal rub (a painful stimulus used to assess a patient's neurological status and responsiveness) on patient and observed that the patient was still unresponsive and had a weak pulse. This nurse told CNA to call code blue. Patient was then transferred from shower chair to bed. Chest compressions began immediately. Staff members rushed in with crash cart at bedside and placed back board underneath. Another staff called 911, while using the non-rebreather to deliver oxygen. Another staff focused putting in a peripheral IV line for fluid. Blood sugar was checked. O2 sat 58% according to pulse oximetry. Resident started moaning and moving his lower extremities just before 911 ambulance arrived to take over. Resident was later taken to the hospital. * On [DATE] at 11:28 a.m., the DON wrote, IDT met to discuss [CR #1]. During review, it was noted that resident's order for O2 ,d+[DATE]LPM was incorrectly typed and should have been ,d+[DATE]LPM as resident order verified for ,d+[DATE]LPM upon resident admission with NP. Resident admitted ,d+[DATE] at approximately 5:15 from hospital on 5L of O2 [saturating] at 98% with diagnosis of Pulmonary Fibrosis, UTI, Aphasia . On ,d+[DATE], resident participated in physical therapy, speech therapy, and occupational therapy. During therapy session, resident was on 5L of oxygen and oxygen was monitored throughout session and remained between 86% and 95% on 5LPM per NC. Later in the day, around 3:00 p.m. resident was taken for a shower. Resident was taken to the shower with oxygen and remained on oxygen therapy throughout the duration of the shower. Shower CNA [A] stated that during his shower, he had his oxygen on, and was alert throughout the course of his shower. Towards the end, resident began to appear weak. CNA [A] called to CNA [B] to come assist. When CNA [B] was transferring the resident back down to his room, resident began to slump in his chair. CNA [F] assisted with getting resident to the room and called to the nurse for assistance with family at bedside. When the nurse arrived at the room, resident was unresponsive to stimuli, RN [E] called code blue and CPR was initiated. Oxygen was changed from NC to NRB and [O2] sat noted to be at 58%. 911 was called by other staff. When EMS arrived, resident had pulse and was responsive. Record review of CR #1's PT Evaluation and Plan of Treatment completed by the PT and dated [DATE] revealed, . Cardiopulmonary Assessment - At rest: . Oxygen saturation: 98 (on 5 L). Activity: Patient's rated/reported level of exertion = Patient is unable to communicate exertion felt during activity. Oxygen saturation with activity: 86 [%](on 5L) . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's EMS records dated [DATE] revealed, . Call Received: 3:51 p.m. On Scene 3:59 p. m.Depart Scene: 4:41 p.m. Chief Complaint: Patient is a [AGE] year-old male with complaints of unconscious and respiratory distress. Patient is unconscious, cannot sit up and cannot ambulate with assistance . History: The issue with cardiac arrest began more than 5 minutes ago . Treatment (Plan): Stopped CPR and found spontaneous pulses and irregular respirations . SPO2 (4:06 p.m.: 89%), (4:16 p.m.: 96%) . Record review of CR #1's hospital records dated [DATE] revealed he was transferred from the facility to the ER then ICU of a local acute care hospital on [DATE]. He was intubated and was diagnosed with cardiac arrest (when the heart suddenly stops beating). The document read in part, . Brought in by EMS [from facility]. CPR in progress upon EMS arrival, staff was doing compressions. Patient was moving around and had a pulse but decreased respiratory effort . Physical Exam ([DATE]) General: He is in acute distress. Appearance: He is ill-appearing . Pulmonary: Patient is having assisted ventilation . Neurological: Unresponsive . Observation and interview with CR #1 on [DATE], at 2:45 p.m. revealed he was in the ICU at a local acute care hospital. CR #1 was intubated and opened his eyes to verbal stimuli. CR #1 did not attempt to communicate or make any gestures unless a family member spoke to him. There were multiple family members present at that time. Two family members stated they were present at the facility when CR #1 was admitted to the facility on [DATE]. Both family members stated they informed staff at the facility they would have to increase CR #1's oxygen to 6 - 8 L/min while he was in the shower as they had to do at home. The family members stated the DON told them staff had equipment in the shower to monitor CR #1's oxygen. One family member said CR #1 was able to tell them he remembered being at the facility, but he could not recall what happened in the shower. Another family member who only spoke Spanish (translated by an English speaking family member) stated CR #1 complained about the oxygen in that place and he told her through nodding and gestures that he did not have what he needed. CR #1 did not answer questions at that time. In an interview with the DON on [DATE], at 9:45 a.m., she stated CR #1 was admitted on [DATE] and was sent out on [DATE] when he coded in respiratory/cardiac arrest around 4:00 p.m. She said CR #1's oxygen saturation dropped significantly, and he was non-responsive. She said CR #1 received therapy on [DATE] and then he was taken to the shower. The DON said while CR #1 was going back to his room, he became week and then became unresponsive. She said CR #1 was on continuous oxygen and had it on the whole time he was in the shower. She said she investigated the incident after CR #1 was discharged to the hospital on [DATE]. She said CR #1 never went without his oxygen while he was at the facility. She said he transferred from the hospital on [DATE] on 5 L/min of oxygen. She said she verified with the nurses, CNA's and therapist that CR #1 was always on 5 L/min. The DON said she would have gotten a physician's order for more oxygen, but CR #1 was tolerating 5 L/min during exertion (she did not specify which exerting activities). She stated throughout CR #1's time in therapy, he remained between 86% and 95% oxygen saturation (according to the American Lung Association, dated [DATE], a person with pulmonary fibrosis should maintain an oxygen saturation level above 90% throughout the day and night). She stated that level was good given his diagnosis of pulmonary fibrosis. She stated when CR #1 went into distress, his oxygen saturation level was 58% on a non-rebreather (a medical device that delivers a high concentration of oxygen). She stated she spoke with CR #1's family and she told them all of CR #1's orders from the hospital indicated he should have been on 2 - 4 L/min of oxygen, but up to 5 L/min if in distress. She stated CR #1 could not walk, he was aphasic, but was alert and aware. She said CR #1 remained alert in the shower until staff transferred him back to his room in a wheelchair. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNA A on [DATE], at 11:20 a.m., she stated she worked at the facility as a shower aide. She stated she only interacted with CR #1 one time ([DATE]). She said she had never seen CR #1 before he was brought to her in the shower room on [DATE]. She said the assigned CNA brought residents to the shower room and went back to pick them up after their shower to go back to their rooms. She said when CNA B brought CR #1 to the shower room, he was on oxygen via nasal cannula and in a shower chair. She said she tried to communicate with CR #1, but he did not really talk. She said CR #1 may have said some words, but they were in Spanish. She said CR #1 was not breathing heavily or abnormally. She said CR #1 seemed to be weak. She said during the shower, she did all the work, other than raising his arm when she asked him to. She said she was in the shower alone with CR #1 until CNA B came back to get him. She said she only looked at CR #1's portable oxygen tank when he initially arrived at the shower room, and he was on 5 L/min. She said she had to carry the portable tank and she saw 5 L/min and it was full. She said she carried the tank over to where she dried and dressed CR #1. She said the only time she noticed a change in CR #1 was when CNA B looked inside the door after he was dressed. She said she told CNA B that she did not think CR #1 looked too good. She said CR #1's color changed, and he looked pale to her. She said CR #1's breathing was the same (normal) and he was sitting straight up in his chair, not slumped over. She said all CNAs were trained to recognize changes of condition, including respiratory distress. She said the only way she could have known if CR #1's oxygen was on was if she checked the nasal cannula to see if air was coming out because the oxygen did not make sound. She said she did not check CR #1's oxygen after the shower started. In a telephone interview with CR #1's family member on [DATE], at 11:32 a.m., she stated CR #1 was currently in the ICU and the family was asked to place him on hospice (specialized care that provides physical comfort and emotional, social, and spiritual support for people nearing the end of life). She said when she spoke to the facility's DON after CR #1 was transferred to the hospital, she said maybe the hospital discharged CR #1 before he was ready. She stated CR #1's oxygen never decreased (desaturated) as low as it did on [DATE]. She said CR #1 was almost unresponsive when he returned to his room, and she wanted to know how he got to that point because it never happened before. She said CR #1's oxygen levels were never an issue at the hospital prior to his admission to the facility. She stated the hospital doctor told her that CR #1's oxygen level went too low, and his body shut down and it looked like cardiac arrest. She said CR #1's baseline oxygen requirement was 4 L/min at rest and 6 - 8 L/min with exertion. She said CR #1 had therapy on Friday, [DATE] and the therapist told her they had to increase his oxygen while in therapy. She said she informed the admitting nurse on Thursday, [DATE], and the therapist on Friday, [DATE] they would have to increase CR #1's oxygen to 6 - 8 L/min on exertion, including walking and showers. She said the DON told her CR #1 was on 4 L/min when they took him to the shower. She said another family member was in CR #1's room on [DATE] when staff took him to the shower. She said the other family member said they were in the shower for 30 minutes and when CR #1 returned to his room, he was slumped over and unresponsive. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the PT on [DATE], at 12:15 p.m., she stated she evaluated CR #1 on [DATE] and she did not know he was transferred to the hospital until [DATE]. She said she went to CR #1's room on [DATE] to evaluate him for physical therapy and occupational therapy right after breakfast. She said when she arrived at his room, he was in bed with oxygen on via nasal cannula. She stated CR #1 was aphasic and was not able to verbalize, but he used gestures and pointed to things to communicate. She stated he did speak in a mix of broken Spanish and English and he was able to follow directions. She said she worked with CR #1 on walking from the bed to the bathroom door, about ,d+[DATE] feet. She said CR #1 did alright, but she noticed he was exhibiting signs of SOB, so she checked his oxygen. She said she could not recall what CR #1's oxygen saturation was. She said she instructed CR #1 to breath properly and deeply. She said CR #1 followed instructions and his oxygen saturation went up without increasing his oxygen. She said she assisted CR #1 back to bed and told him he would start therapy. She said she told his nurse (RN E) CR #1's oxygen saturation decreased when she walked him, so the nurse was aware. She said she wanted to get information about CR #1's baseline, so she called his family member. She said CR #1 was already breathing heavily when he was lying down before therapy because she could see his chest and stomach rise and fall. She said CR #1 was on 5 L/min of oxygen according to his physician's order. She said when she called CR #1's family member after the evaluation, the family member mentioned that at home, he was on 5 L/min. She said she did not increase CR #1's oxygen during the evaluation because she did not have the authority to do that, and he was fine after doing proper breathing exercises. In a telephone interview with CR #1's NP on [DATE], at 12:57 p.m., she stated CR #1 admitted on [DATE] after she had already completed rounds at the facility, so she never met him. She stated she did not recall speaking to anybody regarding his medications, so staff must have verified his physician's orders with the on-call physician. She stated it was hard to say if 1 L/min of oxygen would have made a difference for CR #1. She said with his history of pulmonary fibrosis, usually a higher oxygen level did not guarantee better perfusion of lungs. She said she did receive a report that CR #1's blood pressure was slightly low (she could not recall when she received this report), so she called the DON to go assess and recheck, but his blood pressure was normal at that time. She stated there was nothing different she would have done for CR #1 with no symptoms and the nurses reported no symptoms and no distress. She said she did not receive a report that CR #1's oxygen saturation decreased during physical therapy. She said she was not an expert in that area (respiratory/pulmonary), so she did not know if going to the shower could have caused a change of condition so quickly. She said sometimes, therapy and showers could be a lot for a resident. She said she thought CR #1 was not ready to leave the hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with RN E on [DATE], at 12:09 p.m., she stated she only worked with CR #1 on Friday, [DATE]. She said when she arrived for her shift that morning (6:00 a.m. - 6:00 p.m.) she assessed CR #1 and found that his blood pressure was low. She said she could not recall what his blood pressure was, but she took it twice. She gave CR #1 fluids and when the ADON returned to check the blood pressure again at the NP's request, it was normal. She said later that morning, when physical therapy came, CR #1's oxygen was low, and he was weak. She said the PT told her CR #1 walked back and forth from the door to the bed and then his family member said when he was at home and doing therapy, they increased his oxygen to 7 and 8 L because his oxygen dropped during exertion. She said after lunch, she was on her way to another hall when a CNA called for her. She said a CNA brought CR #1 back from a shower and said he did not look ok. She said she looked at CR #1 and she had a flash-back of what the PT said about his oxygen in therapy. RN E said she looked at CR #1 and he looked ok, so she told the CNA to take CR #1 to his room. She said CR #1 looked weak but had oxygen on. RN E said the activity of the shower may have dropped CR #1's oxygen down. She said she told the CNA she was coming, but on her way back, about one minute later, the CNA came running down the hall and said CR #1 looked worse. She said she went to CR #1's room and he looked different and was unconscious. She said she started to do a sternal rub. She said she told the CNA to call a code blue and she started CPR. She said before they went to the shower, CR #1 was on a small oxygen tank. She said the oxygen was on, but she could not recall what level it was on. RN E initially said CR #1 was on 3 L/min of oxygen. RN E said she could not recall if the tank was full, but she knew it was working. RN E eventually said CR #1 was on 5 L/min of oxygen and when she looked at it, it was fine. She said CR #1 and CNA B were already in front of the shower room when she saw them. She said when CR #1 went unconscious, he was still in the shower chair. She said she checked for a pulse, but it was weak. She said they transferred CR #1 to the bed and started CPR. She said EMS came when he was already awake. She said CR #1 did not look pale to her when he came out of the shower. She said he looked weak, and she thought it was because he was used to increasing his oxygen during showers. She said she did not call CR #1's doctor to ask about increasing his oxygen after his oxygen saturation decreased during therapy, even though she was informed his family said to increase it. She said it was not even an hour after the PT told her that before the shower incident happened. She said she was already waiting on the doctor to respond to her about CR #1's critical CO2 lab result. She said after the PT told her about CR #1's desaturation during therapy, she received CR #1's critical lab and called for the doctor regarding the lab. In an interview with the ADON on [DATE] at 11:30 a.m., she stated she was the one who entered CR #1's orders for oxygen into the MAR. She said after reading the hospital record, she understood CR #1 was tolerating ,d+[DATE] L of oxygen. She said she did not know the order was supposed to be 5 L. She said 5 L was the most a nasal cannula could tolerate. She said she had no interactions with CR #1's family until the code blue. She said she did not know where 6 - 8 L/min of oxygen came from. She said if CR #1's family said he was tolerating 6 - 8 L at home, his NP should have been contacted. She said that was the steps staff should have taken if the family said they wanted CR #1 on something different. She said the staff should have gotten guidance from the NP or doctor and educated CR #1's family that they got orders from medical providers. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN D on [DATE], at 12:05 p.m., she stated she admitted CR #1 to the facility on [DATE]. She said CR #1 was on 5 L, so she left him on 5 L. She said CR #1's family said when he was at home, if he walked or moved around the house, they increased his oxygen 6 L. She said if she was working with him, she would have increased his oxygen in the shower if his family said that. She said she verified CR #1's medications with the NP by text. She said the NP instructed to continue with the admission orders. LVN D said she did not ask the NP about CR #1's oxygen administration and she did not enter his medications in the MAR. She said the nurse who admitted the resident was supposed to enter the medication, but she did not. She said she did not know why she did not enter the medications, she must have forgotten. She said once everything was explained to her, she knew it was her fault (the medication/oxygen error). She said there were no orders for oxygen from the hospital, but when the hospital gave report, it said 5 L. In a telephone interview with CR #1's family member on [DATE] at 9:17 p.m., she stated CR #1 expired on [DATE] while at home on hospice care. Record review of the facility's policy titled Significant Change of Condition, Response revised ,d+[DATE] revealed, It is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. Procedure. 1. If, at ant time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be the following (but not limited to): Change or a trending change in vital signs, to include temperature, pulse, blood pressure, heart rate, and oxygen saturation. Change in a [TRUNCATED]

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on observation, interview, and interview, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice and the resident's goals and preferences for 1 of 9 residents (CR #1) reviewed for respiratory care. 1. The facility failed to increase CR #1's oxygen or consult/seek further guidance from CR #1's physician to increase his oxygen to ,d+[DATE] L/min during a shower on [DATE] after his family members informed staff his oxygen requirement increased during exerting activities, including showers. The facility failed to monitor CR #1's oxygen administration/O2 levels while in the shower and ensure CR #1's oxygen was working properly or immediately call for a nurse when CNA A and CNA B noted a change of condition (CR #1's skin color was pale). This resulted in CR #1's drastic desaturation (a decrease in oxygen saturation, low blood oxygen concentration) to 53%. CR #1 lost consciousness and required CPR and intubation (a medical procedure that involves inserting a flexible tube into the trachea to help maintain an open airway). CR #1 expired on [DATE] on hospice at his home. 2. The facility failed to notify CR #1's physician or seek medical guidance when he experienced a drop in oxygen saturation during physical therapy on [DATE]. 3. The facility failed to accurately document CR #1's order for 5 L/min of continuous oxygen on his MAR and instead listed ,d+[DATE] L/min of continuous oxygen. An IJ was identified on [DATE] at 2:52 p.m The IJ template was provided to the facility on [DATE] at 2:52 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the severity level at a potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on [DATE]. These failures placed residents on continuous oxygen at risk of experiencing desaturation, unconsciousness, and death. Findings include: Record review of CR #1's face sheet, dated [DATE] revealed he was a [AGE] year-old male who was admitted to the facility on [DATE] from an acute care hospital. He was diagnosed with UTI (an illness in any part of the urinary tract), diabetes mellitus type 2 (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), aphasia (a language disorder that affects a person's ability to communicate), acute and chronic respiratory failure with hypoxia (a condition where you do not have enough oxygen in the tissues in your body [hypoxia] or when there is too much carbon dioxide in your body. It can happen all at once [acute] or come on over time [chronic]), and essential hypertension (a form of hypertension without an identifiable cause). CR #1 was discharged to an acute care hospital on [DATE]. Record review of CR #1's MDS dated [DATE] revealed he was admitted from an acute care hospital on [DATE]. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's BIMS dated [DATE] at 2:55 p.m. revealed he had a score of 0 (severe cognitive impairment). Record review of CR #1's Functional Abilities Admission assessment dated [DATE] revealed, MDS Reason for Evaluation: Admission/5-Day . Self-Care: Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury - Independent - Resident completed all the activities by themselves, with or without an assistive device, with no assistance from a helper . Prior Device Ise - Manual Wheelchair, [NAME] . Record review of CR #1's care plan dated [DATE] revealed the following care area: * ADL Self Care Performance Deficit. Goal included: Will safely perform bed mobility, transfers, eating, dressing, grooming, toilet use, and personal hygiene with modified independence. Interventions included: Occupational, Physical, Speech-Language Therapy evaluation and treatment per physician orders; Toilet Use: requires assistance; Transfers (Chair /Bed to Chair Transfer, toilet transfers: Requires staff participation with transfers; Bed Mobility: Requires staff participation to reposition and turn in bed; Encourage to participate to the fullest extent possible with each interaction; Bathing (Shower/Bathe Self): Staff will provide the required assistance needed for bathing; Personal Hygiene/Oral care: Staff will provide the required assistance needed for personal hygiene/oral care; Dressing: Requires staff participation to dress; Eating: Staff will provide the required assistance needed for eating as needed. Further review of CR #1's care plan revealed no focus/care area related to his respiratory condition or oxygen requirements/needs. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's preadmission hospital records dated [DATE] revealed he was admitted to a local acute care hospital on [DATE] for weakness and was diagnosed with complicated UTI (any UTI that is not considered simple, and defined by the presence of underlying conditions rather than the severity of the infection), acute on chronic respiratory failure with hypoxia, acute toxic metabolic encephalopathy (a condition that causes global cerebral dysfunction, resulting in altered consciousness, behavior changes, and seizures), acute diarrhea due to E.coli (diarrhea caused by bacteria), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), pulmonary fibrosis (a condition in which the lungs become scarred over time), acute on chronic congestive heart failure (a type of heart failure that occurs when the heart has difficulty compensating for a loss of function that has developed over time) and history of CVA (a stroke; when blood flow to the brain is suddenly cut off) with global aphasia (a severe form of non-fluent aphasia caused by damage to the left side of the brain). The document read in part, . [CR #1] is a [AGE] year-old male with pulmonary fibrosis who was hospitalized for metabolic encephalopathy and atrial fibrillation with rapid ventricular response due to complicated UTI and infectious diarrhea. Patient improved with supportive measures including antibiotics and rate control. Patient was discharged in stable cardiology and pulmonology for continued evaluation and management as outpatient . Review of Systems . Respiratory: Negative for cough, shortness of breath, and wheezing . Respiratory/Pulmonary Interventions Documentation: . Respiratory Quality/Sounds: Dyspnea (shortness of breath) on exertion, dyspnea laying flat, dyspneic (having difficulty breathing or being unable to breathe without effort), tachypneic (fast breathing) . Respiratory/Pulmonary Interventions: O2 Delivery Method: Nasal cannula; O2 flow rate (L/min): 5 L/min . [DATE] . History of Present Illness . He was on baseline O2 of ,d+[DATE] L/min . Patient was admitted for further evaluation . He developed episode of a-fib and SOB/cough overnight, given breathing treatments and IV metoprolol (a medication used to treat high blood pressure, chest pain, and heart failure) . Currently he is resting in bed, no acute distress. On 6L/min via nasal cannula . Pulmonary and Critical Care Consult Note, [DATE]. Assessment: Chronic hypoxic respiratory failure with home oxygen dependence between 4 to 6 L/min at baseline, 8L with exertion . Pulmonary Progress Note: [DATE] . Patient states his breathing feels comfortable at his baseline oxygen requirement of 5L/min . He has been saturating at 100% . Record review of CR #1's Initial Admission Record dated [DATE] revealed LVN C wrote . Most Recent O2 saturation: 98% ([DATE] at 5:15 p.m.) Method: oxygen via nasal [cannula] . General Skin Condition: Normal - Yes, Pale/Ashen - No, Flushed - No, Cyanotic (bluish or purple discoloration) - No . Pulmonary System. Diagnosis: Does the Resident have a Pulmonary Diagnosis - No . Pulmonary System. Oxygen. Oxygen Use - No . Record review of CR #1's physician's orders for [DATE] revealed: * Check and record O2 Saturation every shift. Order Date: [DATE]. Start Date: [DATE]. * O2 at ,d+[DATE] L/Min Continuous per nasal cannula every shift. Order Date: [DATE]. Start Date: [DATE] Record review of CR #1's MAR for [DATE] (there was no MAR for [DATE]) revealed: * Check and record O2 Saturation every shift. There were no entries for this order. CR #1 was hospitalized . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	* O2 at ,d+[DATE] L/Min Continuous per nasal cannula every shift. There were no entries for this order. CR #1 was hospitalized . Record review of CR #1's progress notes for [DATE] revealed: On [DATE], LVN D wrote, At 5:15 p.m., patient arrived as a new admit to the facility via wheelchair with belongings . O2: 98% 5L of O2. NP notified of admit and verified orders and lab orders for CBC and BMP. Record review of CR #1's progress notes for [DATE] revealed: * On [DATE] at 1:57 p.m., LVN E wrote, COC for CO2 of 45 (normal range 21.0 - 31.0). Resident has a critical lab of CO2 45, NP informed and awaiting new orders. * On [DATE] at 6:08 p.m., LVN E wrote, Resident had just finished taking a shower when the CNA [CNA B] brought out the resident from the bathroom looking weak but breathing. This nurse told the CNA to take resident back to his room. Later this nurse was called by CNA that resident is not looking good. This nurse did a sternal rub (a painful stimulus used to assess a patient's neurological status and responsiveness) on patient and observed that the patient was still unresponsive and had a weak pulse. This nurse told CNA to call code blue. Patient was then transferred from shower chair to bed. Chest compressions began immediately. Staff members rushed in with crash cart at bedside and placed back board underneath. Another staff called 911, while using the non-rebreather to deliver oxygen. Another staff focused putting in a peripheral IV line for fluid. Blood sugar was checked. O2 sat 58% according to pulse oximetry. Resident started moaning and moving his lower extremities just before 911 ambulance arrived to take over. Resident was later taken to the hospital. * On [DATE] at 11:28 a.m., the DON wrote, IDT met to discuss [CR #1]. During review, it was noted that resident's order for O2 ,d+[DATE]LPM was incorrectly typed and should have been ,d+[DATE]LPM as resident order verified for ,d+[DATE]LPM upon resident admission with NP. Resident admitted ,d+[DATE] at approximately 5:15 from hospital on 5L of O2 [saturating] at 98% with diagnosis of Pulmonary Fibrosis, UTI, Aphasia . On ,d+[DATE], resident participated in physical therapy, speech therapy, and occupational therapy. During therapy session, resident was on 5L of oxygen and oxygen was monitored throughout session and remained between 86% and 95% on 5LPM per NC. Later in the day, around 3:00 p.m. resident was taken for a shower. Resident was taken to the shower with oxygen and remained on oxygen therapy throughout the duration of the shower. Shower CNA [A] stated that during his shower, he had his oxygen on, and was alert throughout the course of his shower. Towards the end, resident began to appear weak. CNA [A] called to CNA [B] to come assist. When CNA [B] was transferring the resident back down to his room, resident began to slump in his chair. CNA [F] assisted with getting resident to the room and called to the nurse for assistance with family at bedside. When the nurse arrived at the room, resident was unresponsive to stimuli, RN [E] called code blue and CPR was initiated. Oxygen was changed from NC to NRB and [O2] sat noted to be at 58%. 911 was called by other staff. When EMS arrived, resident had pulse and was responsive. Record review of CR #1's PT Evaluation and Plan of Treatment completed by the PT and dated [DATE] revealed, . Cardiopulmonary Assessment - At rest: . Oxygen saturation: 98 (on 5 L). Activity: Patient's rated/reported level of exertion = Patient is unable to communicate exertion felt during activity. Oxygen saturation with activity: 86 [%](on 5L) . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's EMS records dated [DATE] revealed, . Call Received: 3:51 p.m. On Scene 3:59 p. m.Depart Scene: 4:41 p.m. Chief Complaint: Patient is a [AGE] year-old male with complaints of unconscious and respiratory distress. Patient is unconscious, cannot sit up and cannot ambulate with assistance . History: The issue with cardiac arrest began more than 5 minutes ago . Treatment (Plan): Stopped CPR and found spontaneous pulses and irregular respirations . SPO2 (4:06 p.m.: 89%), (4:16 p.m.: 96%) . Record review of CR #1's hospital records dated [DATE] revealed he was transferred from the facility to the ER then ICU of a local acute care hospital on [DATE]. He was intubated and was diagnosed with cardiac arrest (when the heart suddenly stops beating). The document read in part, . Brought in by EMS [from facility]. CPR in progress upon EMS arrival, staff was doing compressions. Patient was moving around and had a pulse but decreased respiratory effort . Physical Exam ([DATE]) General: He is in acute distress. Appearance: He is ill-appearing . Pulmonary: Patient is having assisted ventilation . Neurological: Unresponsive . Observation and interview with CR #1 on [DATE], at 2:45 p.m. revealed he was in the ICU at a local acute care hospital. CR #1 was intubated and opened his eyes to verbal stimuli. CR #1 did not attempt to communicate or make any gestures unless a family member spoke to him. There were multiple family members present at that time. Two family members stated they were present at the facility when CR #1 was admitted to the facility on [DATE]. Both family members stated they informed staff at the facility they would have to increase CR #1's oxygen to 6 - 8 L/min while he was in the shower as they had to do at home. The family members stated the DON told them staff had equipment in the shower to monitor CR #1's oxygen. One family member said CR #1 was able to tell them he remembered being at the facility, but he could not recall what happened in the shower. Another family member who only spoke Spanish (translated by an English speaking family member) stated CR #1 complained about the oxygen in that place and he told her through nodding and gestures that he did not have what he needed. CR #1 did not answer questions at that time. In an interview with the DON on [DATE], at 9:45 a.m., she stated CR #1 was admitted on [DATE] and was sent out on [DATE] when he coded in respiratory/cardiac arrest around 4:00 p.m. She said CR #1's oxygen saturation dropped significantly, and he was non-responsive. She said CR #1 received therapy on [DATE] and then he was taken to the shower. The DON said while CR #1 was going back to his room, he became week and then became unresponsive. She said CR #1 was on continuous oxygen and had it on the whole time he was in the shower. She said she investigated the incident after CR #1 was discharged to the hospital on [DATE]. She said CR #1 never went without his oxygen while he was at the facility. She said he transferred from the hospital on [DATE] on 5 L/min of oxygen. She said she verified with the nurses, CNA's and therapist that CR #1 was always on 5 L/min. The DON said she would have gotten a physician's order for more oxygen, but CR #1 was tolerating 5 L/min during exertion (she did not specify which exerting activities). She stated throughout CR #1's time in therapy, he remained between 86% and 95% oxygen saturation (according to the American Lung Association, dated [DATE], a person with pulmonary fibrosis should maintain an oxygen saturation level above 90% throughout the day and night). She stated that level was good given his diagnosis of pulmonary fibrosis. She stated when CR #1 went into distress, his oxygen saturation level was 58% on a non-rebreather (a medical device that delivers a high concentration of oxygen). She stated she spoke with CR #1's family and she told them all of CR #1's orders from the hospital indicated he should have been on 2 - 4 L/min of oxygen, but up to 5 L/min if in distress. She stated CR #1 could not walk, he was aphasic, but was alert and aware. She said CR #1 remained alert in the shower until staff transferred him back to his room in a wheelchair. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the ADON on [DATE], at 10:55 a.m., she stated she had never seen CR #1 until [DATE], when the code blue (used to indicate that a patient requires resuscitation or is in need of immediate medical attention) was called. She said she got involved because she heard the code blue. She said when she went to CR #1's room, she assisted other staff with moving him from the shower chair to his bed and then she provided chest compressions during CPR. She said they initiated CPR in CR #1's bed with a back board. She said CR #1 had a weak pulse and responded well to chest compressions. She said CR #1 began to make noises and then she assessed his pupils. She said CR #1 blinked hard and then started moving his legs before EMS arrived. She said CR #1 had a nasal cannula and was on a portable oxygen tank until staff traded out for the ambu bag (a manual resuscitator or self-inflating bag) to administer breaths. She stated the portable oxygen tanks had a gauge on it which indicated how much oxygen it contained. She said all the portable oxygen tanks went up to 5 L/min. She stated she never sat and watched a portable oxygen tank as it administered oxygen, so she could not say how long a small portable oxygen tank (like the one used in the shower with CR #1) would last on 5 L/min. She stated the tank did not make a sound if it was going empty. She said staff charged (filled the tanks with oxygen) the portable tanks regularly and they would not have put CR #1 on a used (one that was not full) tank. She said normal protocol would be for the CNA or nurse to go get a portable tank. She said a CNA would tell a nurse when a resident was about to take a shower and the CNA would ask the nurse to swap the resident from the oxygen concentrator (the resident would have been on an oxygen concentrator inside their room) to a portable tank. She said the nurse would check to make sure the portable tank was full. In an interview with CNA A on [DATE], at 11:20 a.m., she stated she worked at the facility as a shower aide. She stated she only interacted with CR #1 one time ([DATE]). She said she had never seen CR #1 before he was brought to her in the shower room on [DATE]. She said the assigned CNA brought residents to the shower room and went back to pick them up after their shower to go back to their rooms. She said when CNA B brought CR #1 to the shower room, he was on oxygen via nasal cannula and in a shower chair. She said she tried to communicate with CR #1, but he did not really talk. She said CR #1 may have said some words, but they were in Spanish. She said CR #1 was not breathing heavily or abnormally. She said CR #1 seemed to be weak. She said during the shower, she did all the work, other than raising his arm when she asked him to. She said she was in the shower alone with CR #1 until CNA B came back to get him. She said she only looked at CR #1's portable oxygen tank when he initially arrived at the shower room, and he was on 5 L/min. She said she had to carry the portable tank and she saw 5 L/min and it was full. She said she carried the tank over to where she dried and dressed CR #1. She said the only time she noticed a change in CR #1 was when CNA B looked inside the door after he was dressed. She said she told CNA B that she did not think CR #1 looked too good. She said CR #1's color changed, and he looked pale to her. She said CR #1's breathing was the same (normal) and he was sitting straight up in his chair, not slumped over. She said all CNAs were trained to recognize changes of condition, including respiratory distress. She said the only way she could have known if CR #1's oxygen was on was if she checked the nasal cannula to see if air was coming out because the oxygen did not make sound. She said she did not check CR #1's oxygen after the shower started. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with CR #1's family member on [DATE], at 11:32 a.m., she stated CR #1 was currently in the ICU and the family was asked to place him on hospice (specialized care that provides physical comfort and emotional, social, and spiritual support for people nearing the end of life). She said when she spoke to the facility's DON after CR #1 was transferred to the hospital, she said maybe the hospital discharged CR #1 before he was ready. She stated CR #1's oxygen never decreased (desaturated) as low as it did on [DATE]. She said CR #1 was almost unresponsive when he returned to his room, and she wanted to know how he got to that point because it never happened before. She said CR #1's oxygen levels were never an issue at the hospital prior to his admission to the facility. She stated the hospital doctor told her that CR #1's oxygen level went too low, and his body shut down and it looked like cardiac arrest. She said CR #1's baseline oxygen requirement was 4 L/min at rest and 6 - 8 L/min with exertion. She said CR #1 had therapy on Friday, [DATE] and the therapist told her they had to increase his oxygen while in therapy. She said she informed the admitting nurse on Thursday, [DATE], and the therapist on Friday, [DATE] they would have to increase CR #1's oxygen to 6 - 8 L/min on exertion, including walking and showers. She said the DON told her CR #1 was on 4 L/min when they took him to the shower. She said another family member was in CR #1's room on [DATE] when staff took him to the shower. She said the other family member said they were in the shower for 30 minutes and when CR #1 returned to his room, he was slumped over and unresponsive. In an interview with the PT on [DATE], at 12:15 p.m., she stated she evaluated CR #1 on [DATE] and she did not know he was transferred to the hospital until [DATE]. She said she went to CR #1's room on [DATE] to evaluate him for physical therapy and occupational therapy right after breakfast. She said when she arrived at his room, he was in bed with oxygen on via nasal cannula. She stated CR #1 was aphasic and was not able to verbalize, but he used gestures and pointed to things to communicate. She stated he did speak in a mix of broken Spanish and English and he was able to follow directions. She said she worked with CR #1 on walking from the bed to the bathroom door, about ,d+[DATE] feet. She said CR #1 did alright, but she noticed he was exhibiting signs of SOB, so she checked his oxygen. She said she could not recall what CR #1's oxygen saturation was. She said she instructed CR #1 to breath properly and deeply. She said CR #1 followed instructions and his oxygen saturation went up without increasing his oxygen. She said she assisted CR #1 back to bed and told him he would start therapy. She said she told his nurse (RN E) CR #1's oxygen saturation decreased when she walked him, so the nurse was aware. She said she wanted to get information about CR #1's baseline, so she called his family member. She said CR #1 was already breathing heavily when he was lying down before therapy because she could see his chest and stomach rise and fall. She said CR #1 was on 5 L/min of oxygen according to his physician's order. She said when she called CR #1's family member after the evaluation, the family member mentioned that at home, he was on 5 L/min. She said she did not increase CR #1's oxygen during the evaluation because she did not have the authority to do that, and he was fine after doing proper breathing exercises. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676194	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Mason Creek Transitional Care of Katy		STREET ADDRESS, CITY, STATE, ZIP CODE 21727 Provincial Blvd Katy, TX 77450	

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with CR #1's NP on [DATE], at 12:57 p.m., she stated CR #1 admitted on [DATE] after she had already completed rounds at the facility, so she never met him. She stated she did not recall speaking to anybody regarding his medications, so staff must have verified his physician's orders with the on-call physician. She stated it was hard to say if 1 L/min of oxygen would have made a difference for CR #1. She said with his history of pulmonary fibrosis, usually a higher oxygen level did not guarantee better perfusion of lungs. She said she did receive a report that CR #1's blood pressure was slightly low (she could not recall when she received this report), so she called the DON to go assess and recheck, but his blood pressure was normal at that time. She stated there was nothing different she would have done for CR #1 with no symptoms and the nurses reported no symptoms and no distress. She said she did not receive a report that CR #1's oxygen saturation decreased during physical therapy. She said she was not an expert in that area (respiratory/pulmonary), so she did not know if going to the shower could have caused a change of condition so quickly. She said sometimes, therapy and showers could be a lot for a resident. She said she thought CR #1 was not ready to leave the hospital. In a telephone interview with CNA B [DATE], at 1:30 p.m., she stated [DATE] was the first day she worked with CR #1. She said she met CR #1 when she made her first rounds on [DATE] (she could not recall wheat time it was). She said she was told by the previous shift that CR #1 required extensive assistance and he required oxygen. She said CR #1 did not speak English, but a family member who arrived after breakfast was able to translate. She said CR #1 said he was ready to take a shower, so she went to get a shower chair. She said CR #1 was on an oxygen concentrator in his room, so she got a portable tank and switched him from the concentrator to the tank. She said she told RN E she was going to get CR #1 for a shower because she needed to know what level of oxygen to put him on. She said the nurse said to put him on 5 L/min. She said as she pushed CR #1 down the hall in the shower chair, she had another Spanish staff member to verify that CR #1 could feel the oxygen from his nasal cannula. She said she left CR #1 in the shower room with his oxygen on after she took his gown and brief off. She said CNA A texted to let her know CR #1 was ready. She said CR #1 was fine at first, but as they went down the hall, he looked pale. She said she told RN E and she said to get CR #1 to his room, and she would go assess him. She said once she got to CR #1's room, he passed out. She said in the oxygen room, the full and empty tanks were separated. She said she regularly transported another alert and oriented resident on continuous oxygen (4 L/min) to and from the shower, and she never had problems with oxygen running out. She said when she picked CR #1 up from the shower, CNA A said CR #1 did not look the same. CNA B said CR #1 was not breathing heavily when she picked him up from the shower room, but when he was almost to his room, he started passing out. She said she was trained to change residents from the oxygen concentrator to the portable tanks and vice versa. She said she did not look at the portable oxygen tank when she picked CR #1 up because it should have been full when she put him on. She said CR #1 was in the shower for ,d+[DATE] minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676194	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Mason Creek Transitional Care of Katy		STREET ADDRESS, CITY, STATE, ZIP CODE 21727 Provincial Blvd Katy, TX 77450	

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a follow-up interview with the DON on [DATE], at 1:30 p.m., she stated she was present when CR #1 admitted to the facility. She said CR #1 was on 5 L/min of oxygen when he arrived, but she wanted to clarify with his doctor. She said she read the hospital records and CR #1 was on 4 - 5 L/min, so she wanted to talk to the doctor because they typically kept residents no higher than 4 L/min. She said the on-call doctor was contacted to verify CR #1's medications and they gave an order for 5 L/min. She said there was a typo in the electronic MAR for 2 - 4 L/min because the 4 was so close to the 5 on the keyboard. She said CR #1's family members told her at home, CR #1 he was on 8 L/min via nasal cannula. She said she told the family members that was not best route because the nasal cannula could only tolerate up to 6 L/min. She said she told them the facility had to get orders to increase the oxygen from what was on his hospital records. She said the CNAs were trained to switch residents from the concentrator to portable tanks as long as the nurse assessed the resident, and the nurse went in and made sure the resident was on the proper oxygen. She said it was ok for CNA B to switch CR #1 from the concentrator to the tank because the nurse saw the resident and he went to physical therapy as well. She stated she did not contact CR #1's physician about increasing his oxygen administration to ,d+[DATE] L/min during exertion because he tolerated 5 L/min well. In an interview with multiple hospital nurse managers and one hospital physician on [DATE], at 10:00 a.m., one nurse stated CR #1 had six hospital stays and three ER visits in 2024. The nurse stated CR #1 arrived at the hospital on [DATE] in cardiac arrest but it was hard to say whether his blood pressure dropped first and caused his oxygen to drop, or if his respiratory distress caused his blood pressure to drop. Another nurse stated CR #1's cardiac arrest was due to his respiratory desaturation. The physician stated CR #1's condition deteriorated over time, and he had become more and more short of breath. He said CR #1's chronic lung disease and the probability that he did not have enough air could have led to a quick desaturation. He stated 8 L of oxygen may not have made a difference, but in the shower, CR #1 would have required a little bit more oxygen. He said since it was an acute event, he did not know if 8 L of oxygen would have made a difference. He said CR #1 was diagnosed with aspiration pneumonia (a type of lung infection due to a relatively large amount of material from the stomach or mouth entering the lungs) and his prognosis was poor. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with RN E on [DATE], at 12:09 p.m., she stated she only worked with CR #1 on Friday, [DATE]. She said when she arrived for her shift that morning (6:00 a.m. - 6:00 p.m.) she assessed CR #1 and found that his blood pressure was low. She said she could not recall what his blood pressure was, but she took it twice. She gave CR #1 fluids and when the ADON returned to check the blood pressure again at the NP's request, it was normal. She said later that morning, when physical therapy came, CR #1's oxygen was low, and he was weak. She said the PT told her CR #1 walked back and forth from the door to the bed and then his family member said when he was at home and doing therapy, they increased his oxygen to 7 and 8 L because his oxygen dropped during exertion. She said after lunch, she was on her way to another hall when a CNA called for her. She said a CNA brought CR #1 back from a shower and said he did not look ok. She said she looked at CR #1 and she had a flash-back of what the PT said about his oxygen in therapy. RN E said she looked at CR #1 and he looked ok, so she told the CNA to take CR #1 to his room. She said CR #1 looked weak but had oxygen on. RN E said the activity of the shower may have dropped CR #1's oxygen down. She said she told the CNA she was coming, but on her way back, about one minute later, the CNA came running down the hall and said CR #1 looked worse. She said she went to CR #1's room and he looked different and was unconscious. She said she started to do a sternal rub. She said she told the CNA to call a code blue and she started CPR. She said before they went to the shower, CR #1 was on a small oxygen tank. She said the oxygen was on, but she could not recall what level it was on. RN E initially said CR #1 was on 3 L/min of oxygen. RN E said she could not recall if the tank was full, but she knew it was working. RN E eventually said CR #1 was on 5 L/min of oxygen and when she looked at it, it was fine. She said CR #1 and CNA B were already in front of the shower room when she saw them. She said when CR #1 went unconscious, [TRUNCATED]