STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676263	A. Building B. Wing	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deerbrook Skilled Nursing and Rehab Center	9250 Humble-Westfield Rd Humble, TX 77338

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #21) of 5 residents reviewed for care plans. The facility failed to ensure Resident #21's fall mat was at the bedside according to her care plan. This failure could place residents at risk of injury. The findings include: Record review of Resident #21's face sheet dated 2/28/25 revealed a [AGE] year-old female who readmitted on [DATE]. Her diagnoses included Alzheimer's disease, schizoaffective disorder, bipolar type, anxiety disorder, drug induced subacute dyskinesia (abnormal involuntary movements), and abnormal posture. Record review of Resident #21's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15 which indicated severe cognitive impairment. Staff assessed her mental status as severely impaired. She required assistance from staff with ADL care. She had two falls without injury since Admission/Entry or Reentry or Prior Assessment (whichever is more recent). Record review of Resident #21's care plan last reviewed 2/21/25 revealed she had actual falls related to dementia, gait/balance problems and incontinence. Interventions were to have bilateral (two sides) floor mats, date initiated 10/21/24. In an observation and interview on 2/27/25 at 11:49 a.m. of Resident #21 revealed she was lying in bed. There were no fall mats on either side of her bed. She said she fell out of bed but not recently. She said when she first arrived at the facility there were floor mats but it stopped. In an interview on 2/28/25 at 12:37 p.m. the DON said interventions on the care plan should be followed. She said if a fall mat was listed on Resident #21's care plan it should be out. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Deerbrook Skilled Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9250 Humble-Westfield Rd Humble, TX 77338	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 2/28/25 at 12:40 p.m. of Resident #21's room with the DON revealed Resident #21 was lying in bed. There were no fall mats at the bedside. In an interview on 2/28/25 at 1:10 p.m. with Resident #21's assigned nurse, LVN A. She said she was unsure if Resident #21 needed a fall mat and would have to review the care plan. She said the resident fell out of the bed before and tried to get up sometimes. She said she had not seen fall mats in her room. She said the aides could review the Kardex/tasks on PCC to determine if the resident required a fall mat. She said the fall mat did not pop up in the physician orders. In an interview on 2/28/25 at 1:31 p.m. CNA C said Resident #21 could use a fall mat because the resident thought she could get up and go to restroom and would sometimes put her foot out of the bed. She said she had not seen a fall mat in the room this week. In an interview on 2/28/25 at 1:39 p.m. with Resident #21's assigned CNA, CNA V. She said Resident #21 had a fall mat a couple of months ago when she was in a different room. She said the resident moved to a different room, but the mats did not go with her, and was unsure why. She said the resident used to try to get out of bed a lot but did not try to get out as much now. She said she occasionally swung her legs. She said the Kardex (care plan chart or template) would inform her if a resident needed a fall mat. In an interview on 2/28/25 at 4:15 p.m. the Administrator said the purpose of the care plan was to outline the plan of care on a person-centered basis in accordance with the residents' unique requirements of care. She said the nurses reviewed the care plan and the POC should also have the requirements of care for the resident. She said it had been 2-3 months since Resident #21's last fall and nurses should ensure the fall mat was in place. Record review of the facility's Care Planning - Interdisciplinary Team policy dated September 2013 read in part, .our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. Record review of the facility's Falls - Clinical Protocol policy dated April 2007 read in part, . treatment/management: 1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38644 47722 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living (ADL's) received the necessary services to maintain nutrition, grooming and personal and oral hygiene for 3 of 5 residents (Residents #50, #84 and #82) reviewed for ADL's. The facility failed to ensure Resident #50 and Resident #84 received showers per facility schedule. The facility failed to ensure Resident #82 was provided fingernail care. This failure could place residents at risk for infection, discomfort, and dignity issues. Findings included: Record review of Resident #50's undated face sheet revealed he was an [AGE] year-old male admitted originally on 6/16/24, with the most recent admission being 2/10/25. He had diagnoses of osteomyelitis (bone infection caused by bacteria or fungi), muscle weakness, difficulty in walking, type 2 diabetes mellitus, COPD, absence of right toes, and peripheral vascular disease (a slow and progressive disorder of the blood vessels). Record review of Resident #50's Admission MDS dated [DATE] revealed a BIMS score of 4 out of 15, which indicated he had severely impaired cognition. He had impairment on both sides of his lower extremities and used a wheelchair. Resident #50 was substantial/max assistance (helper does more than half the effort) with shower/baths. He was frequently incontinent of bladder and bowel. According to the MDS, Resident #50 had diabetic foot ulcers and was on IV antibiotics. Record review of Resident #50's Care Plan dated 2/11/25 revealed he had an ADL self-care performance deficit r/t weakness and would improve the level of function through the review date. Interventions revealed he was substantial/max assistance with bathing. Record review of Resident #50's shower sheet from 2/1/25 through 2/27/25 revealed 1 response of Yes to the question, Did you bathe the resident? on 2/25/25 between 2/10/25 to 2/26/25. In an observation and interview on 2/24/25 at 10:14 a.m., revealed Resident #50 was sitting in a wheelchair in his room with his right foot bandaged and in a boot. He was very hard of hearing and had to communicate via writing on a piece of paper. Resident #50 said he had not had a bath/shower since he had been at the facility. 2. Record review of Resident #84's undated face sheet revealed he was a [AGE] year-old male admitted on [DATE] with diagnoses of acute respiratory failure, muscle weakness, abnormalities of gait and mobility, cerebral infarction (stroke), and COPD. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #84's Admission MDS dated [DATE] revealed a BIMS score of 15 out of 15, which indicated normal cognition. The resident had impairment on both sides of his upper and lower extremities and used a wheelchair. He was dependent (helper does all of the effort) with all ADL's. The resident was frequently incontinent of bowel and bladder. Record review of Resident #84's Care Plan dated 1/14/25 revealed he had an ADL self-care performance deficit r/t weakness that he would improve through the review date. Interventions included being dependent with bathing. Record review of Resident #84's shower sheet from 2/1/25 through 2/27/25 revealed 1 response of Yes to the question, Did you bathe the resident? on 2/4/25 between 2/1/25 and 2/19/25. Record review of the February 2025 Grievance Log revealed Resident #84's family member filed a grievance on 2/19/25 about the resident not receiving showers. In an observation and interview on 2/24/25 at 9:41 a.m., revealed Resident #84 was sitting in a wheelchair and had limited mobility of his arms/hands. Resident #84 and his family member said he had not received a shower in 2 weeks. He said he had a stroke, and he forgets to ask for a shower and then they didn't give him one. In an interview on 2/28/25 at 1:00 p.m., Resident #84 said his shower days were Tuesday/Thursday/Saturday. He said he had received 2 showers the day before on 2/27/25. In an interview on 2/28/25 at 1:06 p.m., CNA O said the shower schedule depended on if the resident was at the front of the hall or the back of the hall, and if they were A bed or B bed. She said they gave their residents showers/baths on the 200 hall. In an interview on 2/28/25 at 1:08 p.m., LVN B said the even numbered rooms received showers on Monday/Wednesday/Friday and the odd numbered rooms received showers/baths on T/Th/S. The beds by the door received them on the day shift and the beds by the window received them on the night shift. She said a resident could always ask for a shower/bath on their off day and they would try to accommodate them. She said if a resident did not get a shower/bath they could get an infection. In an interview on 2/28/25 at 4:10 p.m., the ADM said she expected staff to give showers/baths as they were scheduled or requested, and there were enough staff to provide all of them. She said Resident #84's family had spoken to her about the resident not receiving showers/baths and she took care of the issue. She said if residents were not getting showers/baths it was a dignity issue and they could get skin breakdown or skin irritation. In an interview on 2/28/25 at 4:31pm, the DON said she expected the staff to give showers/baths on the resident's scheduled days. She said she had not had any CNAs told her that they did not have time or needed help. She also said during Angel rounds they checked to ensure residents looked clean and presentable and should have known if residents were showered or not. The DON said Resident #84's family told her that he had not had a shower/bath in 2 weeks. She said she took care of the issue, and he received a shower on 2/27/25. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Record review of Resident #82's face sheet dated 2/27/25 revealed a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included right hand contracture (structural changes to your soft and connective tissues that cause them to stiffen, tighten and contract), muscle weakness, type 2 diabetes, and cerebral infarction (stroke). Record review of Resident #82's quarterly MDS assessment, dated 12/13/24 revealed a BIMS score of 0 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care. Record review of Resident #82's care plan reviewed 12/2/24 revealed she had an ADL self care performance deficit related to CVA ((stroke), weakness. Interventions indicated she was dependent with bathing and required partial/moderate assistance with personal hygiene. Observation on 2/25/25 at 10:01 a.m. of Resident #82 revealed her fingernails on both hands were about 0.3 cm long and had a brown substance underneath the nails, the nails appeared dirty. Her right hand was contracted and was in a semi-closed position. She smiled but did not respond when asked if she would like her nails cut. In an observation and interview on 2/27/25 at 1:08 p.m. CNA V observed Resident #82's nails and said they were too long, not clean, and needed care. She said it had been approximately one or two months since she last clipped Resident #82's nails. She said she worried that her nails could dig into her contracted hand. She said she previously asked for nail supplies but there were no clippers, files or sticks available in the facility. In an observation and interview on 2/27/25 at 1:18 p.m. LVN C observed Resident #82's nails and said they were very long and needed to be cut and cleaned. In an observation and interview on 2/27/25 at 1:28 p.m. of the central supply room revealed there were nail supplies available in the desk drawer. Central Supply Staff said she never cut Resident #82's nails and primarily cut residents nails who went to the dining room. In an observation and interview on 2/27/25 at 1:32 pm the Administrator observed Resident #82's nails and said they should not be that long. In an interview on 2/28/25 at 12:32 p.m. the DON said the CNAs were responsible for monitoring and cleaning nails during showers. She said the nurses should cut the nails if the resident was diabetic. She said if nails were not clipped and cleaned it could cause injury and have an effect on infection control and hygiene. She said residents could get sick or injure themselves. In an interview on 2/28/25 at 12:50 p.m. LVN A said she never cut Resident #82's fingernails. She said the CNAs normally cut the residents nails and no aide notified her that Resident #82's nails needed to be cut. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Care of Fingernails/Toenails policy revised April 2007 revealed in part, .the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections . 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on observation, record reviews, and interviews, the facility failed to ensure a resident's environment remained as free of accidents and hazards as possible for 1 of 6 residents (CR #1) reviewed for accidents and hazards in that: - The facility failed to ensure the environment remained free of accident and hazards when CNA D and CNA W transferred CR #1 from her wheelchair to the bed on 2/2/25, and she sustained a laceration to her R leg requiring 15 sutures and 18 staples. An Immediate Jeopardy (IJ) was identified on 2/26/25. The IJ template was provided to the facility on [DATE] at 4:30pm. While the IJ was removed on 2/28/25 at 4:40pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm, with the potential for minimal harm that is not immediate jeopardy, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for serious injuries and hospitalization . Findings included: Record review of Resident CR#1's undated face sheet revealed she was an [AGE] year-old female originally admitted on [DATE], with the most recent admission being 2/2/25. She had diagnoses of muscle weakness, unsteadiness on feet, muscle wasting and atrophy (loss of muscle mass and strength,), end stage renal disease on dialysis (kidneys stopped filtering so a machine does it), reduced mobility, glaucoma (vision loss and blindness damaging the nerve in the back of the eye), lymphedema (swelling caused by buildup of lymph fluid in the body between skin and muscle), and cognitive communication deficit (difficulty communicating that's caused by a brain injury or other cognitive impairment). Record review of CR #1's Admission MDS assessment dated [DATE] revealed a BIMS Score of 11 out of 15, which indicated moderately impaired cognition. She had impairment on one side of her lower extremities. According to the MDS, transfers were not attempted due to CR #1's medical condition or safety concerns. She was dependent on staff (helper does all of the effort and resident does none of the effort. Or the assistance of 2 or more helpers is required.) for ADL's. Record review of CR #1's Care Plan dated 12/26/24 revealed the resident sustained a skin tear to her R lower leg (Initiated: 2/2/25). The goal was to not have any infection to the skin tear through the review date (Initiated: 2/2/25, Target: 4/6/25). Interventions included the resident was transferred to the ED for eval/tx. Keflex (antibiotic) for 10 days. Monitor for s/s of infection and report any negative findings to the MD. The Care Plan also revealed CR #1 had an ADL self-care performance deficit r/t weakness that was initiated on 1/2/25. The goal was to improve the current level of function through the review date and was initiated on 1/2/25 with a target date of 4/6/25. According to the interventions, CR #1 required total assistance with transfers. Record review of CR #1's PT note from 1/31/25 revealed her precautions/contraindications were: High fall risk, HOYER pad in wc at all times. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR #1's Progress Note from 2/2/25 at 1:55pm by LVN B revealed, Resident was assessed with no new skin issues noted. VS are stable. Denies pain at this time. On call was notified of resident return. Resident alert and oriented and able to voice needs and concerns. Will continue to monitor. Record review of CR #1's Change in Condition Note from 2/2/25 at 2:10pm by LVN B revealed, Resident noted with a large skin tear to right outer LE. Pressure DS applied. Record review of CR #1's Progress Note from 2/2/25 at 2:10pm by LVN B revealed, CNA called this writer to resident room and noted resident in bed with a large skin to the right lower leg with moderate amount of bleeding. Resident denies pain at this time and appears in good spirit. Pressure DSG was applied to area. Both CNAs states that while attempting to transfer resident into bed that resident RLE got caught on the side of the bed resulting in skin tear. Resident states her leg got caught on side of bed while the aides was attempting to sit her on the on the bed . Record review of CR #1's hospital records from 2/2/25 at 4:10pm said the resident presented to the ED with a R leg laceration after getting it caught on a metal bed. According to the records, the resident had a leg laceration [tear or cut in the skin or underlying tissues] and partial skin avulsion [forceful tearing away of tissue or body parts, like skin, muscle, or bone], wound irrigated extensively, multilayer sutures placed along with staples . The laceration was 6.2 inches long and 0.78 inches deep. The resident received 15 sutures and 18 staples according to hospital records. Record review of CR #1's Physician's Orders revealed the following orders from MDS: - Cleanse skin tear one time only for 1 Day RLE with NS and apply pressure dsg. Ordered 2/2/25. - Monitor R Leg wound sight each shift. Ordered 2/2/25. - Remove staple and sutures in 14 days. Ordered 2/2/25. - Keflex (Cephalexin) 500 MG Oral Give 1 capsule by mouth. Ordered on 2/3/25. - Location of wound: Right lateral (outside) calf, skin tear PAIN CODE INTERVENTION, Every shift. Ordered 2/6/25. Record review of the facility's Provider Report from 2/2/25 revealed at about 2:15pm CR #1 arrived at the facility from home via family transportation. The SW grabbed a facility wheelchair, and the family transferred the resident from the family vehicle into the wheelchair and then rolled her into the facility. The family requested CR #1 be transferred into bed, so the SW asked CNA W to transfer CR #1 into bed. CNA W got CNA D to help her with the transfer. The CNAs raised the resident, pivoted her and sat her on the bed. When the aides lifted the resident's legs up on the bed, they noticed a skin tear to the outer portion of her lower leg. According to the Provider Report, The bed was inspected and though there were no jagged edges noted, there appeared to be blood on the side rail located on the base of the bed with a blunt opening. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with CNA D on 2/26/25 at 9:04am she said CNA W asked her to come in and assist with putting CR #1 to bed. She said both CNAs transferred her into the bed. When they went to swing her legs into the bed, she saw blood on her hands. She asked CNA W if that was blood and she said yes, but they didn't see any blood on the w/c. Then they noticed blood on her leg. The blood on her gown was noticeable. In an interview with CR #1's family member on 2/26/25 at 10:21am she said they helped CR #1 into a wheelchair that she grabbed from the facility. She said they rolled CR #1 into the facility and spoke to the SW as soon as they entered the facility. Then they went back to the same room she was in before. She said CR #1 told her the aides were lifting her into the bed and she told them You're tearing my leg. Record review of pictures of CR #1's laceration to her R leg, received on 2/26/25 at 10:41am revealed a deep laceration in the shape of a C, exposing the subcutaneous (the deepest layer of your skin, made up mostly of fat cells and connective tissue) layer. In an interview with CR #1 on 2/26/25 at 10:51 a.m. she said her family member brought her into the facility and they spoke to someone at the nurse's station, but she did not remember who. She said 2 aides transferred her from the wheelchair into the bed. CR #1 said she yelled out and her leg got caught on something on the bed. She said she was wearing a dress when it happened. She said she was out with her family that day and it did not happen before she got back to the facility. In an interview with CNA W on 2/26/25 at 11:10am she said they lined CR #1 up against the bed. They told her on the count of 3 they would transfer her. CNA W said CR #1 said she would help. She said CNA D was on the other side of the bed in case she fell off the other side. CNA W said after she transferred her onto the bed and went to lift her legs, there was blood everywhere. She said she did not see any on the wheelchair but saw some on the bed. CNA W said she did not see anything sticking out of the bed, but she saw something that was supposed to be covered because it looked rough. In an interview with LVN B on 2/26/25 at 11:50am she said she saw CR #1 in the hallway and was talking to her before she went into the room, and she did not have any blood or anything on her before the transfer. She said when the CNA told her to come to the room CR #1 was already lying in the bed and she had a laceration on her leg. LVN B said she saw blood on the floor in CR #1's room, and if it would have happened before she would have seen blood in the hallway. She said CR #1 had a bad skin tear, the worst she's ever seen. LVN B said she put a pressure dressing on it and sent CR #1 out via regular transport. She said the resident came back and she had sutures and staples. LVN B said CR #1 normally used a mechanical lift because she could not do anything. She said the CNAs should have looked at the Kardex (worksheet that summarized patient information) or asked her how the resident transferred. In an interview with the SW on 2/26/25 at 12:06pm she said she was in her office when family stopped by her office and said CR #1 was back, so she went and got a wheelchair, and she notified the nurse. She said she did not notice any blood when the resident came in and the resident was not in any pain. The SW said she did not notice any blood on the floor as she was rolled to her room, in the hallway while she was waiting for her bed to be made, or any blood while she was in the room. The SW said she would have seen the laceration because it was visible. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the ADM on 2/26/25 at 1:15pm she said CR #1 had just got to the facility and family wanted her to be transferred to the bed. She said 2 aides transferred her into the bed and when the aides moved her legs they noticed the blood. The ADM said she did see the laceration and it looked bad, but she did not know if blood would have been seen dripping through the facility. In an observation with the ADM on 2/26/25 at 2:40pm, revealed the bed that was in CR #1's room was noted to have a 1/4 grab bar attached to the side of the bed with a pipe sticking out without a cap on the end, making it rough and a potential hazard. The facility was asked if they had a policy on Accidents and Hazards, but they did not have one. Record review of the facility's policy and procedure on Safe Lifting and Movement of Residents (Revised October 2009) revealed in part: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Resident safety .medical condition will be incorporated into .decisions regarding the safe lifting and moving of residents. Manual lifting of residents shall be eliminated when feasible. Nursing staff .shall assess individual residents' needs for transfer assistance on an ongoing basis. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include: Resident's mobility (degree of dependency. Resident's size. Weight-bearing ability. Cognitive status .Staff responsible for direct resident care will be trained in the use of manual .and mechanical lifting devices .Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary .Enough slings, in the sizes required by residents in need, will be available at all times. As an alternative, residents with lifting and movement needs will be provided with single-resident use disposable slings . An Immediate Jeopardy (IJ) was identified on 2/26/25. The IJ template was provided to the facility on [DATE] at 4:30pm. The Plan of Removal was accepted on 2/27/25 at 3:56pm. The plan of removal reflected the following: Name of Facility: {Facility} Date: February 26, 2025 Immediate action: What corrective actions have been implemented for the identified residents? A. On 02/02/2025 CR#1 involved in alleged deficient practice was discharged to the hospital due to a laceration sustained during a transfer from the wheelchair to the bed. B. On 02/02/2025 the incident involving CR#1 was reported to Health and Human Services. C. On 2/02/2025 at 4 pm the Administrator initiated the investigation, and blood was noted on the side of the bed frame on the square opening area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Deerbrook Skilled Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9250 Humble-Westfield Rd Humble, TX 77338	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	D. On 2/02/2025 CNA D was in-serviced on Referring to Resident POC for Transfer Instruction. E. On 2/02/2025 CNA W was in-serviced on Referring to Resident POC for Transfer Instruction. F. On 2/02/2025 at 5 pm the Maintenance Director conducted an inspection of all beds, and bed frames. Beds that were missing caps on the side of the bed frame were sealed with either a cap or tape. These open areas are generally utilized to attach side rails to the bed frame. G. On 2/02/2025 at 5:20 pm the Maintenance Director placed a tab in the open area identified on CR#1 bed and then aides changed the bed out per family request. H. On 02/03/2025 at 9:00 am the Administrator notified the Medical Director of the alleged deficient practice. I. The Corporate Clinical Service Director reviewed facility policy on 02/03/2025 regarding Safe Lifting and Movement of Residents and no revisions were deemed necessary. J. On 02/02/2025 at 10:09 pm resident CR#1 returned from the hospital with 18 staples and 8 sutures. K. On 2/03/2025 an audit of past incidents was conducted. Two incidents were identified and previously reported to Health and Human Services. Facility's Plan to ensure compliance quickly A. An in-service was initiated on 02/03/2025 by the Administrator and the Assistant Director of Nursing with the aides on Safe Lifting and Movement of Residents, Referring to Resident POC for Transfer Instruction, and Resident Abuse and Neglect. The aides were not allowed to return to work until they received this in-service. The completion date is 2/13/2025. B. On 02/03/2025 the Director of Rehab and the Assistant Director of Nursing completed a 100% checkoff on Resident Transfers with the certified nursing aides. The aides were not allowed to return to work until they received this in-service. The completion date is 2/13/2025. C. Newly hired nurses will be in-serviced by the Assistant Director of Nursing or designee on Safe Lifting and Movement of Residents, Referring to Resident POC for Transfer Instruction, and Resident Abuse and Neglect. D. On 2/06/2025 nursing staff were in-serviced by the Assistant Director of Nursing on Reporting Hazardous Equipment Immediately Including Removing Hazardous Equipment. E. The openings identified by Surveyor were covered and a facility wide audit conducted 2/26/2025. Areas of concern addressed immediately. Tape was applied to two Assist Bars that had openings. F. Ambassador Rounding Sheet that was implemented to monitor bed frames on 2/3/25 was updated 2/26/25 to include the monitoring of the Assist Bars. Ambassadors will also check vacant rooms. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

G. On 2/26/25 nurses were in-serviced by the Director of Nursing on referencing Kardex prior to directing staff including C.N.A.s and staff from other departments on how to transfer residents. The Charge Nurse and Nurse Managers will update the Kardex upon admissions and readmissions with any change(s) in status.

H. On 2/27/25 nurses were in-serviced by Director of Nursing instructing Charge Nurses to assess new and readmitted residents to determine transfer status and to communicate findings to the C.N.A.(s) on duty.

On 2/28/25 a monitoring visit was conducted to ensure the facility was following its POR. The visit revealed:

Record review revealed on 2/2/25 CNA D was in-serviced on abuse and neglect and transfers by the ADM. The in-services given were about reporting abuse and how the resident had the right to be free from abuse and neglect and the importance of safety measures applied when transferring residents.

Record review revealed on 2/2/25 CNA W was in-serviced on abuse and neglect and transfers by the ADM. The in-services were related to reporting abuse and how the resident had the right to be free from abuse and neglect and the importance of safety measures applied when transferring residents.

Record review revealed on 2/2/25 the Maintenance Director conducted an inspection of all beds in the facility. The residents' lifts were also checked in all rooms. Record review revealed the following rooms had beds that were taped: 102D, 102W, 103D, 104D, 105W, 106D, 106W, 109D, 109W, 111D, 111W, 113D, 114W, 115W, 202D, 203D, 204D, 205D, 206W, 207W, 208D, 209W, 210D, 211D, 211W, 212D, 213D, 213W, 214W, 215W, 216D, 302D, 302W, 303D, 303W, 304D, 305D, 306W, 307W, 309D, 310D, 313D, 314D, 315W, 316D, 316W, 401W, 402W, 407D, 407W, 408D, 409D, 410W, 411D, 412D, 412W, 414W, 415D, 415W.

Record review revealed on 2/3/25 an audit of past incidents was conducted and the 2 incidents that occurred were on [CR #2] on 1/14/25 and [Resident #73] on 1/25/25.

Record review revealed on 2/3/25 in-services were given by the ADON and the ADM on safe transfers which included the policy of two-person transfers, safe lifting, and movement of residents. Record review revealed 35 members attended in person and 18 via phone.

Record review revealed in-services were given on 2/3/25 by the ADON/ADM on referring to the POC for transfer instructions and was about ensuring staff referenced the POC to properly transfer a resident, and about requiring 2 people for transfers with a Hoyer transfer. There were 52 staff members who attended in person and 11 via phone.

Record review revealed on 02/03/25 in-services were given by the ADM on ANE, and transfers. The in-services were about ensuring the resident had the right to be free from abuse and neglect, and to ensure treatment that was provided to residents when transferring, was according to the facility policy and protocol. There were 55 staff members who attended in person.

Record review revealed on 2/3/25 in-services were given by the ADON on conducting transfers and newly admitted residents. The in-services were about ensuring new admits and readmits were not transferred prior to being assessed by a nurse, even if family made the request. There were 45 staff in-serviced in person and 18 via telephone.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed on 02/03/2025 in-services were given by the DOR and the ADON on Two Person Stand-Pivot Transfer Competencies and Mechanical/Hydraulic Lifts. There were 80 staff members signatures. Record review revealed on 2/3/25 the ADON gave a new hire orientation regarding transfers, POC and newly admitted residents. The in-services were about ensuring new admits and readmits were not transferred prior to being assessed by a nurse, even if family made the request. Also ensuring staff were referencing the POC to know how the resident transferred and making sure 2 people use the Hoyer lift. There were 8 staff members that were in-serviced in person. Record review revealed on 2/3/25 the ADM gave a new hire orientation on ANE. There were 8 staff members present. Record review revealed on 02/06/2025 the ADON gave in-services on reporting any hazardous equipment. The in-service explained that any equipment that did not look safe needed to be reported to the maintenance director/ADM or reported in the TELS system. All equipment that was defective should be taken out immediately for service. There were 49 staff members who attended in person and 7 via telephone. Record review of the facility wide audit conducted on 2/26/25, including the Assist Bars, revealed no concerns. Record review revealed the template of the ambassador rounding sheet that would be used to monitor bed frames, assist bars, and ensured the checklist was used for vacant rooms. Record review revealed on 2/26/25 the DON in-serviced the CNAs and Nurses on transfers and Kardex's. The in-services were about ensuring the safety of residents who required assistance and ensuring the CNAs used the Kardex prior to transferring, and if they had questions, to ask the charge nurse. The in-services also talked about having a 1 person or 2 people assist, or total dependence on a Hoyer lift transfer. Record review revealed on 2/27/25 the DON in-serviced the nurses on the transfer status for admits/readmits. Nurses were to ensure assessments were completed on residents and readmissions prior to being transferred by any staff, and to educate CNA's on how to complete the transfer. There were 13 nurses who attended the in-service in person and 18 nurses who completed the in-service via telephone. In an interview on 2/28/25 at 1:15pm, LVN A said she was in-serviced on transferring, like assessing the resident's transfer status at admission, telling the aide what kind of transfer they were, and updating the task on the Kardex. She said she was also in-serviced on CIC, for any change like today when a resident received an x-ray for pain. She was also in-serviced on ANE, and the different types of abuse were sexual, physical, mental, and misappropriation. She would report to the ADM (abuse coordinator). (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

In an interview on 2/28/25 at 1:20pm, CNA C said she had in-services on transfers, and making sure the bed/wheelchair was locked, putting a gait belt on, having the resident put their hands on her shoulders, counting to 3, pivoting, and counting to 3 and then sitting. She said they in-serviced about never using a mechanical lift with just one person because an accident could happen. Also, they talked about looking on the Kardex to see how the resident transferred. CNA C said if she saw any hazardous equipment she would report it. ANE was also in-serviced, and the different types of abuse were physical, verbal, mental, sexual, misappropriation. If she were ever to see ANE she would report it to the ADM (abuse coordinator).

In an interview on 2/28/25 at 2:14pm, Med Aide E said they had in-services on transfers, which included always having 2 people when using the mechanical lift, looking on the Kardex for the type of transfers, and using a gait belt. She said they were in-serviced on hazardous equipment, and they informed the nurse if they saw any, and placed the resident in a safe spot first. ANE was also in-serviced, and the types of abuse were physical, verbal, misappropriation, neglect, sexual, and mental. She said if she were to see any ANE she would report it to the ADM (abuse coordinator).

In an interview on 2/28/25 at 2:38pm, CNA F said he had in-services about the mechanical lift and how it was a 2-person activity, and where to find information on transfers like the POC/Kardex. He said if he came across hazardous equipment he would stop and get the nurse and maintenance. CNA F said if a resident was re-admitting after 1 day and he had not worked with the resident before, he would look on the Kardex to see how to transfer the resident.

In an interview with LVN G on 2/28/25 at 2:55pm he said he had in-services on transfers and how there was a book now that was updated as admission/readmissions came in and stated how the resident's transferred. He said he also was in-serviced on ANE, and the different types of abuse were physical, financial, neglect, sexual, mental. He said if he were to see ANE he would report it to the ADM (abuse coordinator). LVN G said he was also in-serviced on mechanical lifts and needing 2 people at all times. He said to find how a resident transferred, you would look at the Kardex. He said if the bed had something wrong with it, he would get a new bed before transferring a resident and report it to maintenance.

In an interview on 2/28/25 at 3:02 p.m., LVN H said she received in-services on transfers and having to assess new admits to determine the safest way to transfer, then she informed the CNA and put it in the transfer book. She said staff could find the transfer status of a resident on the Kardex. She also received in-services on ANE. The different types of abuse were sexual, physical, neglect, misappropriation, and mental. She said if she were to see ANE she would report it to the ADM (abuse coordinator). She said if she saw faulty equipment she would report it to maintenance and take it out of rotation.

In an interview on 2/28/25 at 3:07pm, Med Aide I said she received in-services on ANE, and the different types of abuse were physical, mental, verbal, neglect, misappropriation, and sexual. She said if she were to see ANE she would report it to the ADM (abuse coordinator). She said she also received in-services on transfers and how mechanical lifts required 2 people, ensuring the mechanical lift did not hit someone, using the right size mechanical lift pad, asking the nurse how to transfer the resident, looking at Kardex, and using a gait belt.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 2/28/25 at 3:12pm, CNA J said she was in-serviced on transfers and how the transfer status was on the POC/Kardex, always using 2 people for mechanical lifts, always explaining to the resident what was going on, and always using a mechanical lift mat. The CNA said she also received in-services on ANE, and the different types of abuse were verbal, physical, mental, sexual, and misappropriation. She said if she were to see ANE she would report it to the ADM (abuse coordinator). In an interview on 2/28/25 at 3:21pm, RN K said she received in-services on transfers and about how the admitting nurse was going to determine the resident's transfer status, updated the Kardex, and told the CNA what the transfer status was. She said she also received in-services on mechanical lifts and how 2 people always had to be used, and making sure the right sling was used. ANE was also in-serviced, and the types of abuse were physical, verbal, misappropriation, neglect, and sexual. She said if she ever saw ANE she would report it to the ADM (abuse coordinator). In an interview on 2/28/25 at 3:27pm, CNA L said she received in-services on transfers and if a resident was a 2 person transfer then they had to use 2 people or they could use a mechanical lift. She also received in-services on the use of a gait belt, and how the admission nurse would have to assess the resident before anyone could transfer the resident, and the transfer status would be entered into the transfer book and in the system. She said she was also in-serviced on ANE, and the types of abuse were verbal, physical, sexual, and neglect. She said if she saw any ANE she would report it to the ADM (abuse coordinator). In an observation on 2/28/25 at 3:43pm, revealed CNA M and CNA F performed a mechanical lift transfer. The CNAs strapped the resident in and gave instructions to the resident regarding the lift. They ensured the lift was locked prior to the transfer of the resident. The CNAs placed the lift mat underneath the resident. Then they clipped the mat to the lift and informed the resident that the mechanical lift would be moving up. The CNAs lifted the resident slowly while 1 used the remote and 1 guided the resident. The resident did not hit anything and was placed into his chair smoothly. In an observation on 2/28/25 at 4:03pm, revealed CNA J and CNA N performed a 2 person transfer from wheelchair to bed. The CNAs started off with the bed being low for transfer and they applied a gait belt to the resident. There was constant communication between the resident and staff to ensure the resident was safe during the process. The resident was asked to put her hands on CNA J's shoulder for her comfort during the transfer. On the count of 3 the 2 CNAs picked up the resident from the gait belt, pivoted and sat her down on the bed. Once the resident was sitting on the edge of the bed, CNA J swung the resident's legs over onto the bed. In an interview on 2/28/25 at 4:10pm, the ADM said she expected staff to follow the plan of care/Kardex and reference that first. She said CNA D and CNA W should have looked at the POC/Kardex or spoke to the nurse before transferring CR #1. She said if the aides did not know the transfer status of the resident there was a risk for injury to the resident. In an interview on 2/28/25 at 4:31pm, the DON said they had in-services on transfers and how the nurses would assess residents when admitting them and determine their transfer status, and then enter the transfer status on the Kardex and inform the CNAs and other staff. She said they also had in-services on ANE and the types of abuse. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Immediate Jeopardy (IJ) was identified on 2/26/25. The IJ template was provided to the facility on [DATE] at 4:30pm. While the Administrator was notified the IJ was removed on 2/28/25 at 4:18pm, the facility remained out of compliance at a severity of no actual harm with the potential for minimal harm, that is not immediate jeopardy with a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems.