STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER The Crescent		STREET ADDRESS, CITY, STATE, ZIP CODE 11353 Sugar Park Lane Sugar Land, TX 77478	

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** 47479 Based on interviews, and record review, the facility failed to immediately consult with the resident's physician when there was a need to alter treatment significantly for 1 of 10 residents (CR#1) reviewed for changes of condition . -The facility did not notify CR#1's physician of his changes in condition on [DATE], after which EMS was called, and transported the resident to the hospital where he passed away two days later, on [DATE]. On [DATE] an Immediate Jeopardy (IJ) situation was identified. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility continuing to monitor the implementation and the effectiveness of their Plan or Removal. These failures could place residents at risk of not receiving needed care and services to meet their physical, mental, and psychosocial needs. Findings included: In an interview with the Private Nurse on [DATE] at 8:42 AM, she said she was very concerned about the resident's condition on [DATE]. She said the resident had terminal cancer; however, the resident was alert and very vocal. She said EMS immediately recognized the resident was in distress and needed emergency medical evaluation and treatment. She said the resident was admitted to the hospital on [DATE], and passed away two days later on [DATE]. In an interview with the Transporter on [DATE] at 9:03 AM, she said she was not sure of the exact time but was sure the incident with CR#1 occurred in the afternoon on [DATE]. She said as she was preparing to get the resident up for his appointment, his cell phone rang, and it was his private nurse on FaceTime. She said they both recognized something was not right with the resident. She said the resident was not able to speak and was very weak. She said the resident was always alert, and full of life. She said she thought the resident was having a stroke. She said she did not know what to do, so she called for help for the resident. She said RN A, RN B, and the Treatment Nurse came into the room and began providing care to the resident. (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 progress notes by RN B on [DATE] at 3:16 PM did not reveal that the physician was notified of the resident's change in condition, or any orders provided by the physician. However, the progress note revealed the following: RN B noted, CNA came and notified resident is feeling weak. Resident was on bed. Writer checked resident. Vitals BP: ,d+[DATE] P: 58 Res:18 Temp: 97.5 O2: 94% PRN oxygen. Blood sugar was 218. Nurse administered fluid. Resident eyes open and was responding by name, stated his name. DON came and assessed the patient. Notified NP. Caregiver call EMS. EMS took the patient to the hospital due to caregiver request. In an interview with RN A on [DATE] at 9:40 AM, She said she told RN B to notify the doctor to get order for bloodwork and notify the family. She said protocol if the resident was not stable, was to notify the doctor, family, management, and the DON. She said the DON was already aware because she was there. She said later, she asked RN B if she called the doctor, and RN B said yes. In an interview with RN B on [DATE] at 10:12 AM, she said she notified the wrong NP of the resident's change in condition, via text message, on [DATE]. She said she texted the NP and said the resident was weak and she requested an order for PRN oxygen. She said the NP replied to her text message stating they were not the NP assigned to the resident. She said she did not make any other attempts to contact the resident's NP or MD. She said she did not know why she did not make any other attempts to contact the appropriate physician. She said there was a lot going on that day, and the incident with the resident happened toward the end of her shift. She said failure to notify a physician of a resident's change in condition could put a resident at risk of death. Record review of text message dated [DATE] at 3:14 PM, from RN B to NP B revealed, CR#1 was seen weak. Checked the vitals. Patient was stable. Administered fluids. Can I get an order for oxygen? Record review of text message, dated [DATE] at 3:14 PM, from NP B to RN B revealed, I don't have that pt. In an interview with the DON on [DATE] at 1:20 PM, she said she asked RN B if she contacted the resident's physician and RN B told her yes. She said she reviewed CR#1's electronic health record and RN B noted she contacted the physician. She said she did not know RN B contacted the wrong physician via text message. She said RN B should have contacted the proper physician via telephone, provided a summary of what happened, what care was provided, and waited to receive any orders from the physician. She said the facility protocol did not require the nurses to document who they spoke with, or the mode of communication used when they contacted physicians because each resident had one main physician, and they needed to contact them via phone call. She said it was only appropriate to send a text message when they were not able to get in touch with the physician. She said if RN B called the physician and was not able to reach the physician, RN B was supposed to notify the DON immediately. She said the nurse was also responsible for documenting the notification and any orders given in the resident's electronic health record. She said she did not believe the resident was placed at risk because the resident was not in distress due to experiencing low O2 saturation. She said the resident had recent episodes of syncope (loss of consciousness for a short period of time) and a lower-than-normal O2 saturation level was the resident's baseline. She said RN B should have called the doctor to make notification and documented in the resident's electronic health record. Record review of CR#1's Treatment Administration Records, dated [DATE]-[DATE], did not reveal an incidcation of regular or PRN oxygen use by the resident. However, the treatment administration record revealed the following: Take vitals signs by shift starting [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	.Blood Pressure: [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] .Pulse Oximeter [DATE] 97.00 [DATE] 100.00 [DATE] 98.00 [DATE] 98.00 (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] 98.00 [DATE] 98.00 [DATE] 96.00 [DATE] 97.00 [DATE] 97.00 [DATE] 97.00 [DATE] 98.00 [DATE] 97.00 [DATE] 100.00 [DATE] 97.00 [DATE] 98.00 [DATE] 97.00 [DATE] 98.00 [DATE] 98.00 . Record review of CR#1's Treatment Administration Records, dated [DATE]-[DATE], did not reveal an incidcation of regular or PRN oxygen use by the resident. However, the treatment administration record revealed the following: Take vitals signs by shift starting [DATE]. .Blood Pressure: [DATE] ,d+[DATE] [DATE] ,d+[DATE] .Pulse Oximeter [DATE] 99 [DATE] 98 . Further review of CR#1's treatment administration record did not reveal additional information related to the incident on [DATE]. (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 physician orders, dated [DATE], did not reveal an order from the physician on [DATE] for oxygen. The physician orders also did not reveal a standing order or PRN order for oxygen for CR#1. Further review of the physician orders revealed the resident was full code status, nursing was to perform weekly head-to-toe assessments, and take vital signs each shift.

Further review of the progress notes by LVN A on [DATE] at 4:04 PM did not reveal that the physician was notified of the resident's change in condition, or any orders provided by the physician. However, the progress note revealed the following: LVN A noted, Arrived on shift and received report that patient was lethargic and had a low O2 saturation. DON as well as ,d+[DATE] nurse (LVN A) put patient on O2 to stabilize O2. Levels raised to 98 while in room. Patient assessed every 15 minutes. Shortly after caregiver arrived and called EMS to send patient out to hospital. DON and ADON notified. Vitals: HR:68 RR:19 O2:98 BP:,d+[DATE]

Further review of the progress notes revealed, no physician was notified of the resident's change in condition on [DATE].

Further review of CR#1's progress notes, clinical records, vital signs and physician's orders did not reveal additional information related to the incident on [DATE].

In an interview with LVN A on [DATE] at 2:42 PM, he said he did not notify the resident's physician about the resident's initial change in condition because he was not aware of what care was provided to the resident before his arrival at 2:00 PM. He said he was sure RN B notified the physician while she was wrapping up charting the incident. He said at about 2:45 PM he and the DON went into the resident's room to check on him. He said he checked the resident's vitals and the resident's O2 saturation level was at 88 or 89. He said a normal O2 saturation level was between 93 and 96. He said he cranked the resident's oxygen up to about 15 liters to stabilize the resident's O2 saturation. He said the resident's oxygen level returned to about 93. He said he did not consider notifying the resident's physician about the drop in the resident's O2 saturation level. He said there was a lot going on that day, he felt like the staff came together and did the best they could for the resident.

In an interview with the DON on [DATE] at 3:00 PM, she said she did go into the resident's room with LVN A. She said she was aware LVN A performed an assessment on the resident. She said she did not see, nor was she made aware that the resident's O2 saturation level dropped to 88 or 89. She said they had to switch the resident's oxygen tank out, but the resident never went without oxygen after he experienced the first change in condition. She said she thought LVN A was mistaken because she did not recall the resident's oxygen level dropping that low. She said if LVN A observed the resident's O2 saturation level at 88 or 89, he should have notified her and the physician of an additional change in condition. She said she did not believe the resident was at risk or in any distress because the resident seemed to be doing better since the initial incident. She said failure to notify the physician when a resident experienced a change in condition put residents at risk for re-hospitalization or a decline in health.

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the Administrator on [DATE] at 3:23 PM, she said she was not aware CR#1's physician was not notified of the resident's changes in condition on [DATE]. She said it was her expectation of the nurses to contact physicians to notify them when a resident experienced a change in condition. She said the nurses could contact physicians via text message or phone call. She said the nurses were supposed to notify the physician of what they observed, how they found the resident, the assessment they did, and provide vital signs. She said she did not ask detailed questions regarding CR#1's changes in condition on [DATE] because she trusted her team handled the situation appropriately, based on the feedback provided from the DON, and the staff involved. She said the nurses were trained to use their best judgment, based on their training. She said failure to notify a physician when a resident experienced a change in condition put residents at risk for re-hospitalization or a decline in health. In an interview with the DON on [DATE] at 2:00 PM, she said every day during the morning meeting, the IDT team (the Administrator, the DON, the MDS Coordinators, the Director of Therapy, the Director of Social Services, and the Dietary Manager) reviewed the 24-hour report to make sure all changes in condition were handled appropriately. She said if any issues with accuracy or proper documentation were reviewed, they addressed, and discussed issues during the meeting. She said the nursing team did not handle making notifications to CR#1's physician appropriately. She said the nurses had recently been re-in-serviced to attempt to call the resident's physician via phone at least three times. She said if the nurse was unable to reach the physician on the third call, they were to call the medical director. She said the nurses were also in-serviced to document a summary of what they observed when the resident experienced the change in condition, vital signs, and assessment of the resident prior to contacting the physician. She said the nurses were to document the change in condition in the resident's progress notes or on an SBAR in the electronic health record. She said once the nurse made notification, they also needed to document the physician was contacted, and any orders given by the physician. She said the facility updated all the physician's contact information, so no staff contacted the wrong physician. In an interview with the Administrator on [DATE] at 2:40 PM, she said at the time the IDT team reviewed the 24-hour report after CR#1's changes in condition on [DATE], the IDT team did not see anything wrong with the documentation of notifications to the resident's physician. She said sometimes, people got complacent in their positions. She said the DON possibly needed to review the facility's policies and procedures more often. She said there was always room for the facility's staff to make improvements. She said the nursing team had been re-educated on making notifications to physicians and the facility updated all physician's contact information to ensure accuracy. She said if the facility staff had followed policies and procedures, the outcome of the situation may have been different. Record review of CR#1's face sheet dated [DATE], revealed he was admitted to the facility on [DATE] with diagnoses of chronic kidney disease (gradual loss of kidney function which can cause dangerous levels of fluid, electrolytes, and wastes to build up in the body), malignant neoplasm of the bladder (bladder cancer), malignant neoplasm of the colon (colon cancer), congestive heart failure (long-term condition that occurs when the heart cannot pump a normal blood supply to the body, and blood and fluid collect in the lungs and legs over time), and dehydration (absence of a sufficient amount of water in the body). (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 admission MDS dated [DATE], revealed the resident's BIMS score was 13, which indicated his cognition was intact. CR#1 used a wheelchair, and required set-up or clean-up assistance with eating, oral hygiene, and upper body dressing. He required supervision for personal hygiene and moderate assistance for toileting, lower body dressing, rolling to the left or right, sitting to lying position, sit to stand position, and chair/bed-to chair transfers. Record review of CR#1's baseline care plan, dated [DATE], did not reveal problems, goals, or interventions related to the resident's regular or PRN use of oxygen. Further review of the care plan revealed he was at risk for infections. Interventions included nursing staff assessing him for any symptoms of confusion, changes in mental status, delirium or confusion, following the policy for reportable conditions, and consulting with physician, PA, CNP, therapy, and dietitian. Record Review of Emergency Services records, dated [DATE], did not reveal oxygen provided to the resident, by the facility, on [DATE] prior to EMS' arrival. However, review of the records revealed the following: Call Recieved: 2:58 PM Dispatched: 2:59 PM En Route: 3:00 PM On Scene: 3:03 PM At Patient: 3:06 PM Depart Scene: 3:21 PM Level of Service: Advanced Life Support Transportation Mode Description: Lights and Sirens Clinical Impression Primary Impression: Altered Mental Status Onset Time: 3:00 PM [DATE] Duration: 2 Hours Signs & Symptoms: Hypotension (the pressure of blood circulating around the body is lower than normal or lower than expected), Altered Mental Status (changes in consciousness and symptoms that can affect many organ systems), Tachycardia (a heart rate over 100 beats a minute), Tachypnea (abnormally rapid breathing) Barriers of Care: Psychologically Impaired Initial Patient Acuity: Emergent Assessment Time [DATE] 3:09 PM (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Mental Status: Confused; Unresponsive Skin: Cold; Dry Breath Sounds Clear and Equal Sepsis Screening performed: [DATE] at 3:15 PM qSOFA Criteria Met: Yes SIRS Criteria Met: Yes Sepsis infection suspected or documented: Yes ETCO2 less than 25 mmHg: Yes Systolic Blood Pressure less than 100 mmHg: Yes Respiratory Rate greater than 22 breaths/min: Yes Glasgow Coma Scale less than 15: Yes Temperatire less than 36 celsius or greater than 30 celsius: No Heart Rate greater than 90 bpm: Yes Respiratory Rate greater than 20 breaths/min: Yes Vital Signs Time: 3:08 PM; BP ,d+[DATE]; Pulse 107; RR: 25; SPO2: 100 room air; ETCO2: 21.0 mmHg 3:14 PM; Pulse 72: RR: 38; SPO2 98 room air; ETCO2: 22.0 mmHg 3:15 PM BP: ,d+[DATE]; Pulse: 56; ETCO2: 18.0 mmHg; Temp: 98.1 3:20 PM BP: ,d+[DATE]; Pulse: 93; RR: 25; SPO2: 98 room air 3:24 PM BP: ,d+[DATE]; Pulse: 114; RR: 23; SPO2: 98 room air; ETCO2: 21.0 mmHg 3:28 PM BP: ,d+[DATE]; Pulse: 118; RR: 23; SPO2: 95 room air; 20.0 mmHg 3:32 PM BP: ,d+[DATE]; Pulse: 77; SPO2: 95 room air; ETCO2: 18.0 mmHg 3:37 PM BP: ,d+[DATE]; Pulse: 110; RR: 22; SPO2: 99 room air; ETCO2: 18.0 mmHg Treatments (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The Administrator, the DON, and the ADON were in-serviced by the RDCS (Regional Director of Clinical Services) on Change in Condition and Physician Notification on [DATE]. Staff in-services, to include all licensed clinical staff, were started on Change in Condition and Physician Notification. This in-servicing will continue until all licensed clinical staff have been trained. Staff will not be allowed to start on the floor or give care until this training has been completed. -All new licensed clinical staff will receive the in-services as part of the onboarding orientation process prior to being assigned and providing care to residents. All licensed clinical staff will be in-serviced on change in condition and physician notification. No licensed clinical staff will be allowed to work in the facility until the above required in-services are completed. The in-services with all staff will be completed by [DATE]. All staff were in-serviced [DATE]. -All current residents were assessed to determine if there has been any change in status and/ or condition. The assessments were noted in the individual residents' EMR's. The physician will be made aware of any noted changes from the resident's normal baseline. This will be completed by the licensed/registered nurses and nursing leadership. Completion Date: [DATE] After completion of the resident audits, no other residents were found to be at imminent risk of having a change in condition and at their normal baseline completed [DATE]. Facility reviewed current residents for change in condition in last 30 days and proper reporting, no noncompliance noted completion date [DATE]. Who will be responsible: Nurse Managers and the DON Who Will monitor: Executive Director and Regional Director of Clinical Services (RDCS). Monitoring -Residents will continue to be reviewed and discussed in the daily IDT Meeting by reviewing the 24-hour Report for any changes in condition. Timely follow up and MD notification will occur. Charge nurses and nursing leadership will continue with daily and prn rounds and assessments to ascertain any changes in condition and to follow up the with MD promptly. -Residents will be assessed on admission for baseline and reviewed daily and prn for any changes in status and follow up the physician timely. -Starting [DATE] Director of nursing and/or Nurse Managers will review the 24-hour report for any incident of residents being outside during unfavorable weather conditions, each day for 4 weeks week, then weekly for 4 weeks. The Executive Director will review the documentation each week for compliance. -Beginning [DATE] no staff will be allowed to work until the required in-servicing has been completed. Policy and Procedures (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Crescent		STREET ADDRESS, CITY, STATE, ZIP CODE 11353 Sugar Park Lane Sugar Land, TX 77478	

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Policy and procedures were reviewed by Senior [NAME] President of Operations, Director of Regulatory and Compliance, Senior Executive Director, Regional Director of Clinical Services, Executive Director, and Director of Nursing. These policies include Change in Condition and Physician Notification. No policies needed any revisions. Monitoring of the plan of removal included: The surveyor confirmed the facility implemented their plan of removal sufficiently from [DATE] - [DATE] to remove the IJ by: Reviewed curriculum and competency assessments for RN B and LVN A; topics included Physician Notification Policy & Procedure, Quality of Care - Change of Condition Policy & Procedure, and acknowledgment of updated physician and nurse practitioner contact numbers. Reviewed QAPI meeting notes from [DATE], which included a review of policies and protocols for change in condition and physician notification. The results of the meeting determined both polices to be sufficient. Reviewed curriculum and competency assessments on change in condition, physician notification, SBAR, completed by the Administrator, the DON, the ADON, and all licensed clinical staff between [DATE] and [DATE]. Reviewed the facility's 30-day audit of resident electronic health records for changes in condition and appropriate notification to physicians. Reviewed updated nursing assessments for changes in resident's condition. No unknown changes identified by nursing staff. Reviewed daily schedules of clinical staff on [DATE], [DATE], [DATE], [DATE], and [DATE] to ensure scheduled staff completed necessary in-services and competency assessments prior to shift start. Interviews were conducted with staff from all shifts from [DATE]-[DATE], which included the Administrator, the DON, 10 RN's, and 15 LVN's , across 6:00 AM-2:00 PM, 2:, d+[DATE]:00 PM and 10:00 PM-6:00 AM shifts, regarding all in-services and they were able to explain the policies and procedures related to recognizing, assessing, documenting, notifying physicians of, and providing on-going monitoring after changes in condition. Interviews were conducted with the Administrator and the DON to ensure they understood the importance of maintaining and implementing an effective system for nursing staff to recognize, assess, document, notify physicians of, and provide on-going monitoring after changes in condition. The Administrator was informed the Immediate Jeopardy (IJ) was removed on [DATE] at 4:26 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal arm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47479 Based on interviews and record review, the facility failed to ensure the resident's right to be free from neglect for 1 of 10 residents (CR#1) reviewed for neglect. The facility did not appropriately assess, document assessments, notify the physician, follow physician orders, provide ongoing monitoring, or provide emergency medical treatment in a timely manner, after CR#1 experienced changes in condition on [DATE], after which EMS was called, and transported the resident to the hospital where he passed away two days later, on [DATE]. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place resident at risk of a delay in medical treatment, worsening of condition, infection, and pain. Findings included: In an interview with the Private Nurse on [DATE] at 8:42 AM, she said she was very concerned about the resident's condition on [DATE]. She said the resident had terminal cancer; however, the resident was alert and very vocal. She said the resident was admitted to the hospital on [DATE], and passed away two days later on [DATE]. In an interview with the Transporter on [DATE] at 9:03 AM, she said the resident was not able to speak and was very weak. She said the resident was always alert, and full of life. She said she thought the resident was having a stroke. Record review of CR#1's progress notes by RN B on [DATE] at 3:16 PM did not reveal that the times the events included in the progress note occurred on [DATE]. However, the progress note revealed the following: RN B noted, CNA came and notified resident is feeling weak. Resident was on bed. Writer checked resident. Vitals BP: ,d+[DATE] P: 58 Res:18 Temp: 97.5 O2: 94% PRN oxygen. Blood sugar was 218. Nurse administered fluid. Resident eyes open and was responding by name, stated his name. DON came and assessed the patient. Notified NP. Caregiver call EMS. EMS took the patient to the hospital due to caregiver request. Record Review of CR#1's electronic health record revealed no SBAR was documented when RN B noted a change in the resident's condition on [DATE]. (continued on next page)

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The Crescent	11353 Sugar Park Lane Sugar Land, TX 77478

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with RN A on [DATE] at 9:40 AM, she said on [DATE] after lunchtime or close to lunchtime, RN B called for help from the door of CR#1's room. She said she went into the room and RN B said the resident looked weak. She said the resident was lying in the bed, his skin color was normal, and he did not look like he was in any distress. She said RN B checked his blood sugar and it was normal. She said the Treatment Nurse checked his oxygen level and it was below 92, so they decided to put him on PRN oxygen. She said the whole time, she was doing a sternum rub on the resident. She said she performed the sternum rub by massaging his chest. She said she was also calling the resident's name. She said the resident opened his eyes and he began to talk to her. She said she did not know how long she massaged his chest before he opened his eyes. She said he responded to the sternum rub almost immediately. She said she asked him if he knew where he was, and if he knew who he was. She said the resident said yes and he told her his name. She said they also gave the resident water to drink once he began to speak. She said a CNA came and told her that her patient needed her, so she left. She said the Treatment Nurse and RN B were left behind with the resident. She said RN B was the nurse assigned to the resident at the time. She said she did not have a clear picture of what happened after she left the resident's room because she had a lot of other responsibilities to tend to. She said she did not know for sure but thought emergency services was contacted for the resident. She said RN B and LVN A were both handling the resident's care when EMS arrived. She said failure to ensure residents received emergency medical treatment could potentially cause death. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with RN B on [DATE] at 10:12 AM, she said she was not typically assigned to work on the resident's hall, and was not familiar with him. She said [DATE] was her first time working with him. She said she thought it was around 2:00 PM when she heard a CNA shout from CR#1's room for a nurse. She said when she made it into the resident's room, the Transporter, and a CNA were holding his shoulders while the resident was sort of lying off the side of his bed. She said she could not remember who the CNA was. She said she could not remember the resident's exact positioning, but she knew they had to help him put his feet back into the bed for him to lay down. She said the only thing she noticed was the resident was not talking. She said she called for help and RN A and the Treatment Nurse came in the room to assist. She said the resident's O2 saturation level was low so, she went to get an oxygen mask to administer PRN oxygen. She said she could not remember the resident's exact O2 saturation level, but she knew it was below normal levels. She said she got a blood pressure cuff, gloves, and by the time she came back, the resident's eyes were open. She said the resident did not look pale. She said she did not see, nor was she aware RN A did a sternum rub or massaged the resident's chest. She said she thought the Treatment Nurse also checked his blood pressure because she recalled RN C having a blood pressure cuff too. She said she and RN A were talking to the resident. She said she asked him if he knew who he was and if he was okay. She said after the resident began talking, they gave him some water to drink. She said she could not contact emergency services for a resident because someone said to call 911. She said she had to have doctor's orders to send a resident to the hospital. She said if emergency services needed to be contacted for the resident, the DON was also present in the resident's room, and would have made the call, if it was necessary. She said the resident was speaking, said his name, and he seemed fine. She said he did not appear to be in distress to her. She said she assessed the resident and the only thing in her assessment that was concerning was his O2 saturation level. She said she checked his temperature, blood sugar, blood pressure, respiration, and his O2 saturation. She said she followed his PRN orders and administered oxygen to the resident. She said she did not know how long they were in the resident's room. She said she did not know how much time passed between each round she did, but she returned to the resident's room to monitor him twice before the end of her shift. She said she only checked the resident's vitals during her initial assessment, after being called into the room by the CNA. She said she did not check his vitals or O2 saturation level either time she rounded on the resident. She said she did a visual assessment both times she returned to his room, and he seemed fine. She said LVN A arrived at 2:00 PM, she handed over the shift, gave him report, and stayed at the facility late to finish charting. She said the facility did not have a specific form she was supposed to complete in resident's electronic health record when they had a change of condition, or when she performed an assessment. She said a resident who was in distress and in need of emergency services was at risk of death. She said she did not believe the resident was in distress on [DATE]. She said the resident never fully passed out, and facility staff immediately began checking on the resident to make sure he was okay. She said she followed doctor's orders by administering oxygen and continuing to monitor the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with RN C on [DATE] at 11:59 AM, she said when she got to the resident's room, the Transporter, a CNA, and RN B were already in the room with CR#1. She said herself and RN A went into the room at the same time. She said the resident was lying in his bed on his back. She said the resident was lethargic, his skin was not clammy, he was not sweaty, and his skin had color. She said the nurses were providing care to the resident as a team effort. She said there was a lot of back and forth between the nurses and what they were doing for the resident. She said she could not recall every single detail. She said the resident was not speaking and responded slowly to painful stimuli. She said the painful stimuli she was referring to, was a sternum rub. She said she observed a nurse massage the resident's chest. She said she could not recall which nurse massaged the resident's chest, but remembered the nurse did not have to rub the resident hard or long before he responded to the massage. She said he responded almost immediately to the massage. She said she checked his oxygen saturation, which was below 90, so they had to start him on oxygen. She said RN B checked his blood pressure and his blood sugar. She said low oxygen saturation and high or low blood pressure, or low oxygen saturation level and high or low blood sugar would be an indication a resident was in distress. She said the resident's oxygen saturation was not so critically low that it indicated he was in distress. She said the rest of the resident's vitals were within normal range. She said she did not think the resident was in distress at the time she was present in the resident's room. She said while she was present in the resident's room, no one considered contacting emergency services for the resident. She said before she left the room, the resident was stable, and speaking to the nurses. She said RN B notified the resident's doctor and documented their assessment. She said she felt like the staff did what they could for the resident that day. She said she was not sure who called EMS for the resident. She said she knew the resident expired at the hospital. She said maybe if emergency services had been contacted earlier, the outcome could have been different. In an interview with the DON on [DATE] at 1:20 PM, she said by the time she became aware there was a situation happening with CR#1, RN A, RN B, and the treatment nurse had already wrapped up providing care to the resident. She said she could not recall all the details. She said she went to the resident's room to check on him and he was okay. She said she did not perform an assessment on the resident, herself. She said she was aware the nurses observed the resident to be weak, lethargic, and unable to speak. She said she asked RN B what was done for the resident. She said RN B told her the resident was assessed, had his vitals checked, started him on oxygen, and the nurses gave the resident water. She said she was not aware RN A, and RN C observed the resident with closed eyes and slow to respond to painful stimuli. She said she was not aware any nurse performed a sternum rub or massaged the resident's chest. She said the nurse who performed the sternum rub must not have been familiar with the resident. She said the resident had recent episodes of syncope (loss of consciousness for a short period of time) and a lower-than-normal O2 saturation level was the resident's baseline. She said if the nurse had known, she likely would not have done the sternum rub, or chest massage because it was not necessary. She said she was not aware CR#1's physician was not notified of the resident's change in condition. She said she asked RN B if she contacted the resident's physician and RN B told her yes. She said based on the feedback from the nurses regarding the resident's assessment, vital signs, and baseline of low O2 saturation level, the resident was not in distress, and emergency services did not need to be contacted even though his physician was not notified of his change in condition. She said she was sure the nurses used their best judgement while providing care to the resident. She said the resident was not in distress due to experiencing low O2 saturation. Record review of CR#1's Treatment Administration Records, dated [DATE]-[DATE], did not reveal an incidcation of regular or PRN oxygen use by the resident. However, the treatment administration record revealed the following: Take vitals signs by shift starting [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	.Blood Pressure: [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] [DATE] ,d+[DATE] .Pulse Oximeter [DATE] 97.00 [DATE] 100.00 [DATE] 98.00 [DATE] 98.00 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] 98.00 [DATE] 98.00 [DATE] 96.00 [DATE] 97.00 [DATE] 97.00 [DATE] 97.00 [DATE] 98.00 [DATE] 97.00 [DATE] 100.00 [DATE] 97.00 [DATE] 98.00 [DATE] 97.00 [DATE] 98.00 [DATE] 98.00 . Record review of CR#1's Treatment Administration Records, dated [DATE]-[DATE], did not reveal an incidcation of regular or PRN oxygen use by the resident. However, the treatment administration record revealed the following: Take vitals signs by shift starting [DATE]. .Blood Pressure: [DATE] ,d+[DATE] [DATE] ,d+[DATE] .Pulse Oximeter [DATE] 99 [DATE] 98 . Further review of CR#1's treatment administration record did not reveal additional information related to the incident on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's physician orders, dated [DATE], did not reveal an order from the physician on [DATE] for oxygen. The physician orders also did not reveal a standing order or PRN order for oxygen for CR#1. Further review of the physician orders revealed the resident was full code status, nursing was to perform weekly head-to-toe assessments, and take vital signs each shift. Further review of the progress notes by LVN A on [DATE] at 4:04 PM did not reveal that the times the events included in the progress note occurred on [DATE]. However, the progress note revealed the following: LVN A noted, Arrived on shift and received report that patient was lethargic and had a low O2 saturation. DON as well as ,d+[DATE] nurse (LVN A) put patient on O2 to stabilize O2. Levels raised to 98 while in room. Patient assessed every 15 minutes. Shortly after caregiver arrived and called EMS to send patient out to hospital. DON and ADON notified. Vitals: HR:68 RR:19 O2:98 BP:,d+[DATE] Further review of the progress notes revealed, no physician was notified of the resident's change in condition on [DATE]. Further review of CR#1's progress notes, clinical records, vital signs and physician's orders did not reveal additional information related to the incident on [DATE]. Record review of CR#1's physician orders, dated [DATE], did not reveal an order from the physician on [DATE] for oxygen. The physician orders also did not reveal a standing order or PRN order for oxygen for CR#1. Further review of the physician orders revealed the resident was full code status, nursing was to perform weekly head-to-toe assessments, and take vital signs each shift. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with LVN A on [DATE] at 2:42 PM, he said when he arrived at work on [DATE], he said every time he worked with the resident, he was always alert. He said he was surprised to hear the resident had been unresponsive. He said he received report from RN B. He said she told him the resident was stable, and never indicated that LVN A needed to do anything for the resident based on the situation that occurred prior to his arrival. He said he began rounding on his residents like normal. He said at about 2:45 PM he and the DON went into the resident's room to check on him. He said he checked the resident's vitals and his O2 saturation level was at 88 or 89. He said a normal O2 saturation level was between 93 and 96. He said he cranked the oxygen up to about 15 liters to stabilize the resident's O2 saturation. He said the resident's oxygen level returned to about 93. He said the DON accompanied him to the resident ' s room and he did what she instructed. He did not think about reviewing the resident ' s chart or contacting the physician. He said he trusted what the DON told him to do. He said the DON left, and he stayed with the resident for 20 to 30 minutes to ensure he remained stable. He said he was mistaken and did not document the assessment he performed when the resident's oxygen level dropped to 88. He said he documented the assessment he performed on CR#1 once his O2 saturation level rose back up to the 90's. He said he performed assessments on the resident every 15 minutes after he observed the resident's drop in O2 saturation. He said he did not know the length of time between each assessment, nor did he know how many assessments he performed on the resident. He said he knew each time he performed an assessment, he checked the resident's vitals, and they were stable. He said he checked all the resident ' s vitals, including his BP several times, and documented them all on a scratch sheet of paper he was using on [DATE]. He said he did not know where the scratch sheet of paper would have been located after [DATE]. He said he did not know why did not enter the vital signs in the resident ' s electronic health record. He said he could have been more thorough in his documentation by including what care he provided to the resident and his vital signs. He said he did not consider notifying the resident's physician about the drop in the resident's O2 saturation level. He also said he did not consider calling 911 for the resident. He said the resident had experienced a change in condition prior to the start of his shift, and the DON was aware of the resident's status. He said he felt like the DON would have made sure to call 911 if the resident was in distress. He said he could not recall what time, or exactly what he was doing when CR#1's caregiver showed up at the facility. He said he there was a lot going on that day, and he felt like the staff came together and did the best they could for the resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON on [DATE] at 3:00 PM, she said she did go into the resident's room with LVN A after the resident's first change in condition. She said she was aware LVN A performed an assessment on the resident. She said she did not see, nor was she made aware the resident's O2 saturation level dropped to 88 or 89. She said she was aware the resident's oxygen tank had to be switched out. She said the resident never went without oxygen and did not believe his O2 saturation level dropped as low as 88 or 89, after the resident experienced the first change in condition. She said she thought LVN A was mistaken because she did not recall the resident's oxygen level dropping. She said if LVN A observed the resident's O2 saturation level at 88 or 89, he should have notified her and the physician of an additional change in condition. She said she did not believe the resident was at risk of anything, nor was the resident in any distress when she checked on him with LVN A. She said the resident seemed to be doing better since the initial incident. She said she asked the resident if he was okay, and he said he was tired. She said she left LVN A in the resident's room and left the facility to go to another building. She said she did not know how long she was gone when she received a phone call from LVN A notifying her the caregiver was at the facility and wanted to contact emergency services for the resident. She said it was the caregiver's right to contact emergency services on behalf of the resident. She said the nurses did what was expected of them when they provided care to CR#1 on [DATE]. She said once a resident experienced a change in condition and the doctor had been notified, the nurse was expected to continue monitoring the resident every 15 to 30 minutes. She said during monitoring the nurse was supposed to check vitals, perform a head-to-toe assessment, and document their findings in the resident's electronic health record. She said she was not aware additional monitoring was not done by RN B after the resident experienced the first change in condition. She said RN B should have called the doctor to make notification, documented her initial assessment, and all care provided to the resident, including the fact that they had to do a sternum rub, in the resident's electronic health record. She said RN B should have also continued to monitor and assess and document the assessments after the resident's initial change in condition. She said she saw LVN A perform an assessment on the resident while she was in the resident's room. She said if LVN A did additional assessments, he should have documented what he did for the resident, the findings of his assessment, and the resident's vital signs in the electronic health record every time he monitored the resident. She said she should have made sure RN B and LVN A documented every time they assessed and monitored the resident after the resident was initially weak, lethargic, and unable to speak. She said she did not believe the resident was in distress on [DATE]. She said when Emergency Services arrived at the facility, the resident was not unresponsive, but was alert. She said failure to properly assess a resident and provide emergency medical treatment put residents at risk for re-hospitalization or a decline in health. In an interview with the Administrator on [DATE] at 3:23 PM, she said the nurses were supposed to notify the physician of what they observed, how they found the resident, the assessment they did, and provide vital signs. She said she was not aware the resident did not receive additional monitoring and assessments after his changes in condition on [DATE]. She said the nurses were supposed to document their observations and assessments in the electronic health record. She said she did not ask detailed questions regarding CR#1 on [DATE] because she trusted her team handled the situation appropriately based on the feedback provided from the DON and the staff involved. She said the nurses were trained to use their best judgment, based on their training. She said if the nurses felt the resident was in distress, they knew to contact emergency medical services. She said the nurses were trained to use their best judgment, based on their training. She said if the nurses felt the resident was in distress, they knew to contact emergency medical services. She said failure to perform appropriate assessments and ensure emergency medical treatment in a timely manner put residents at risk for a decline in health. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Crescent		STREET ADDRESS, CITY, STATE, ZIP CODE 11353 Sugar Park Lane Sugar Land, TX 77478	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of CR#1's progress notes, clinical records, vital signs and physician's orders did not reveal an indication of regular or PRN oxygen use by the resident. Further review of CR#1's progress notes, clinical records, vital signs and physician's orders did not reveal additional information related to the incident on [DATE]. In an interview with the DON on [DATE] at 2:00 PM, she said the only thing the nursing team did not handle appropriately on [DATE] was making notifications to CR#1's physician. She said her nursing staff may have been neglectful to point with their documentation and notifications, but not in a way she felt had a direct impact on CR#1's overall health or condition. She said the nurses had recently been re-in-serviced to call the resident's physician. She said moving forward, when there is a change in condition, the nurses were re-in-serviced to call the physician at least three times, and if no answer contact the medical director. She said once the nurse made notification, the nurse needed to document the physician contacted, and any orders given in the electronic health record. She said the facility also updated all physician's contact information to ensure facility staff contacted the appropriate physician. In an interview with the Abuse Prevention Coordinator on [DATE] at 2:40 PM, she said she worked to prevent residents from abuse and neglect daily. She stated she randomly inquired with current residents and new admissions to ensure services and care provided by staff maintained the facility's standards. Staff also know to contact her with concerns of abuse or neglect. She said she also made her 24-hour contact information available at each of the nurse's stations and it was highlighted in the facility's welcome packet for residents. She said residents and families knew to contact her about concerns. She said she also went out on the floor and made random rounds with residents. She said if she ever had a question or concern with abuse or neglect identified within the facility, she would call the Senior Executive Director and Regional Director of Clinical Services immediately. She said at the time the IDT team reviewed the 24-hour report after CR#1's changes in condition on [DATE], the IDT team did not see anything wrong with the documentation of notifications to the resident's physician, or nurses' assessments of the resident. She said she did not want to use the word neglect to describe the incident with CR#1. She said sometimes, people got complacent in their positions. She said the DON possibly needed to review the facility's policies and procedures more often. She said there was always room for the facility's staff to make improvements. She said the nursing team had been re-educated on making notifications to physicians and the facility updated all physician's contact information to ensure accuracy. She said if the facility staff had followed policies and procedures, the outcome of the situation may have been different. Several unsuccessful attempts were made to interview the MD via telephone on [DATE] and [DATE]. Record review of CR#1's face sheet dated [DATE], revealed he was admitted to the facility on [DATE] with diagnoses of chronic kidney disease (gradual loss of kidney function which can cause dangerous levels of fluid, electrolytes, and wastes to build up in the body), malignant neoplasm of the bladder (bladder cancer), malignant neoplasm of the colon (colon cancer), congestive heart failure (long-term condition that occurs when the heart cannot pump a normal blood supply to the body, and blood and fluid collect in the lungs and legs over time), and dehydration (absence of a sufficient amount of water in the body). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's admission MDS dated [DATE], revealed the resident's BIMS score was 13, which indicated his cognition was intact. CR#1 used a wheelchair, and required set-up or clean-up assistance with eating, oral hygiene, and upper body dressing. He required supervision for personal hygiene and moderate assistance for toileting, lower body dressing, rolling to the left or right, sitting to lying position, sit to stand position, and chair/bed-to chair transfers. Record review of CR#1's baseline care plan, dated [DATE], did not reveal problems, goals, or interventions related to the resident's regular or PRN use of oxygen. Further review of the care plan revealed he was at risk for infections. Interventions included nursing staff assessing him for any symptoms of confusion, changes in mental status, delirium or confusion, following the policy for reportable conditions, and consulting with physician, PA, CNP, therapy, and dietitian. Record Review of Emergency Services records, dated [DATE], did not reveal oxygen provided to the resident, by the facility, on [DATE] prior to EMS' arrival. However, review of the records revealed the following: Call Recieved: 2:58 PM Dispatched: 2:59 PM En Route: 3:00 PM On Scene: 3:03 PM At Patient: 3:06 PM Depart Scene: 3:21 PM Level of Service: Advanced Life Support Transportation Mode Description: Lights and Sirens Clinical Impression Primary Impression: Altered Mental Status Onset Time: 3:00 PM [DATE] Duration: 2 Hours Signs & Symptoms: Hypotension (the pressure of blood circulating around the body is lower than normal or lower than expected), Altered Mental Status (changes in consciousness and symptoms that can affect many organ systems), Tachycardia (a heart rate over 100 beats a minute), Tachypnea (abnormally rapid breathing) Barriers of Care: Psychologically Impaired Initial Patient Acuity: Emergent Assessment Time [DATE] 3:09 PM (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Mental Status: Confused; Unresponsive Skin: Cold; Dry Breath Sounds Clear and Equal Sepsis Screening performed: [DATE] at 3:15 PM qSOFA Criteria Met: Yes SIRS Criteria Met: Yes Sepsis infection suspected or documented: Yes ETCO2 less than 25 mmHg: Yes Systolic Blood Pressure less than 100 mmHg: Yes Respiratory Rate greater than 22 breaths/min: Yes Glasgow Coma Scale less than 15: Yes Temperatire less than 36 celsius or greater than 30 celsius: No Heart Rate greater than 90 bpm: Yes Respiratory Rate greater than 20 breaths/min: Yes Vital Signs Time: 3:08 PM; BP ,d+[DATE]; Pulse 107; RR: 25; SPO2: 100 room air; ETCO2: 21.0 mmHg 3:14 PM; Pulse 72: RR: 38; SPO2 98 room air; ETCO2: 22.0 mmHg 3:15 PM BP: ,d+[DATE]; Pulse: 56; ETCO2: 18.0 mmHg; Temp: 98.1 3:20 PM BP: ,d+[DATE]; Pulse: 93; RR: 25; SPO2: 98 room air 3:24 PM BP: ,d+[DATE]; Pulse: 114; RR: 23; SPO2: 98 room air; ETCO2: 21.0 mmHg 3:28 PM BP: ,d+[DATE]; Pulse: 118; RR: 23; SPO2: 95 room air; 20.0 mmHg 3:32 PM BP: ,d+[DATE]; Pulse: 77; SPO2: 95 room air; ETCO2: 18.0 mmHg 3:37 PM BP: ,d+[DATE]; Pulse: 110; RR: 22; SPO2: 99 room air; ETCO2: 18.0 mmHg Treatments (continued on next page)

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The Crescent	11353 Sugar Park Lane Sugar Land, TX 77478

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3:08 PM 12-lead Electrocardiogram; Patient Response: Unchanged 3:09 PM Oxygen Nasal Cannula 2 liters per minute; Patient response: Improved 3:15 PM IV Therapy Saline Lock; Patient Response: Improved 3:24 PM IV Therapy Normal Saline (.9% NaCl); Total FLuid 300 mL; Patient Reponse: Improved 3:24 PM Norepinephrine 10 mcg; Intravenous; Patient Response: Improved 3:25 PM Norepinephrine 10 mcg; Intravenous; Patient Response: Improved EMS dispatched to a medical call .responded with emergency traffic .arrived at the NH without delays. Upon arrival found an [AGE] year-old male lying supine on his hospital-like bed. The patient ' s caregiver was on the scene and explained that she found the patient with an altered mental status and called 911. the patient had been at the NH for a fall he suffered 3 weeks ago, according to the caregiver. The patient was responsive to verbal commands but was confused. It was noted that the patient had low blood pressure, was breathing rapidly, and had a rapid pulse rate. The patient did not present with a fever. EMS promptly placed the patient on the EMS stretcher in the Trendelenburg position and ushered him to the back of the ambulance. The patient was placed on a cardiac monitor, and his blood pressure was monitored. EMS noted the patient had difficult veins and a history of cancer and chemotherapy. EMS initiated emergency traffic to the hospital and sent a sepsis alert to the receiving ER. EMS managed to obtain IV access, initiated a fluid challenge, and administered push-dose norepinephrine. The patient ' s mental status did not improve. It was noted that after the norepinephrine administration, the patient's BP improved. EMS arrived at the ER without delays and registered the patient .While waiting, it was noted that the patient ' s BP was decreasing again, so EMS administered another dose of push-dose norepinephirine. The patient ' s BP improved within a couple of minutes After a few minutes, the patient was given a room and moved to the hospital bed using the bed sheet method. The receiving nurse and doctor were given a verbal report, and patient care was transferred . Review of the policy, revised [DATE], titled, Staffing, Sufficient and Competent Nursing revealed the following: Policy Statement: Our facility provides .nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans .Basic nursing skills; m. Identification of changes in condition; 4. Licensed nurses and nursing assistants are trained and must demonstrate competency in identifying .and reporting resident changes of condition consistent with their scope of practice and responsibilities . Review [TRUNCATED]

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47479 Based on record review and interviews, the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility for 1 of 1 residents (Resident #2) reviewed for transfer and discharge rights. 1.The facility failed to arrange a safe and orderly discharge through care planning and involving Resident #2. 2.The facility failed to secure a home health agency prior to Resident #2's discharge from the facility on 07/15/24. This failure placed residents at risk of not receiving care and services to meet their needs upon discharge. Findings included: Record review of Resident #2's face sheet dated 07/16/24, revealed he was admitted to the facility on [DATE] with diagnoses of Lumbar Region Fusion of Spine (fusion surgery to reduce the motion between two or more vertebrae in the spine to alleviate pain caused by various conditions); Lumbar Radiculopathy (inflammation of a nerve root in the lower back causing pain or irritation in the back and down the legs); Pyogenic Infection of Intervertebral Disc (rare bacterial, pus-producing, spinal infection that can cause pain and lead to neurological problems); and, Presence of Left and Right Artificial Shoulder Joints (functional prosthetic shoulder-joint implants in the left and right shoulders). Record review of Resident #2's admission MDS dated [DATE], revealed the resident's BIMS score was 13, which indicated his cognition was intact. The resident required substantial/maximal assistance with lower body dressing and putting on/taking off footwear; partial/moderate assistance with toileting and shower/bathing; supervision assistance with upper body dressing and personal hygiene; and setup or clean-up assistance with oral hygiene. The resident required partial/moderate assistance with for all positioning and transferring including, lying to sitting on side bed and chair/bed-to-chair transfer. The resident required setup assistance to roll left and right. Further review of the MDS revealed, the resident required occupational and physical therapy and was diagnosed with Malignant Neoplasm of Thyroid Gland (Thyroid Cancer). (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's care plan, dated 07/16/24, revealed the resident had a goal to develop a discharge plan, related to bed mobility needs. Interventions included, prior to discharge, determine all necessary durable medical equipment and assistive devices are available and ready for use; and, utilizing the interdisciplinary team to determine discharge needs, such as home health services, and/or outpatient therapy. The resident experienced bed immobility. Interventions included performing passive ROM (3 repetitions) three times a day; turn and reposition according to the schedule; use specialized mattress; apply heal protector boots as indicated; apply trapeze to bed to aid in self-positioning; utilize transfer aids; apply splints as ordered; follow pain management care plan as indicated for pain caused by bed mobility activities; and, utilize the following durable medical equipment to enhance bed mobility activities. The resident required extensive assistance with turning/positioning in bed; and, transfers to/from bed, chair, wheelchair, standing position. Interventions included use of pillows and foam wedges to maintain position; and, transfer using 1-2 people, and transfer board/lift devices as required. Further review of the care plan revealed, the resident experienced chronic pain. Interventions included daily pain assessments; pain assessments at frequent routine intervals and before/after specific activities; assess change in bowel habits, appetite, and ability to rest/sleep. The resident was also at risk for falls related to generalized weakness. Interventions included reminders to call for assistance before moving from bed-to-chair and from chair-to-bed, and to use ambulation and transfers assist devices; and prompt responses to calls for toilet assistance. Record review of Resident #2's electronic health record from 06/05/24 to 07/15/24 did not reveal notes from an IDT team regarding a summary or discharge plan developed with the resident. Record review of Residents #2'seJuly 2024 progress notes revealed the following: *07/13/24 at 3:33 PM, Social Worker B noted, speaking to the resident's Family Member and deciding to discharge the resident on Monday (07/15/24) with home health and medications and to make sure she has electricity in her home for a safe discharge. *07/13/24 at 9:30 PM, LVN C noted explaining to Resident #2, based on report she received, the resident was to discharge on Monday (07/15/24). LVN C also noted the Family Member was working with Social Services to keep home health in place by Monday (07/15/24). * 07/15/24 at 12:11 PM, RN C noted the discharged today (07/15/24) with home health; discharged teaching was provided and both resident and family member verbalized understanding; meds given to resident per DON; NP notified resident left in stable condition; Family Member provided transportation. Record review of Resident #2's copy of the facility's Discharge Plan of Care, dated 07/15/2024 at 9:32 AM, did not reveal home health or DME services, required equipment or recommendations, pharmacy information, physician signatures, or signatures of facility who provided education or reconciled medications prior to the resident's discharge. Record review of email thread between Administrator and Surveyor, revealed the following: On 07/17/24 at 3:31 PM, the Administrator forwarded an email, of a fax sent via facility copier machine on 07/16/24 at 11:10 AM, by Social Worker A to Resident #2's home health agency. On 07/23/24 at 12:59 PM, the administrator sent an email confirming on 07/16/24 at 11:10 AM Social Worker A sent Resident #1's history and clinical information to the home health agency. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Family Member on 07/16/24 at 9:05 AM, she said there had been tension between Resident #2 and Social Worker A toward the end of the resident's stay at the facility. She said facility staff felt like the resident was being manipulative, but the resident had grown tired of being in the facility and was ready to come home. She said she asked several facility staff, including Social Worker A, the DON, and the administrator about the resident's upcoming discharge. She said initially, the resident was supposed to be discharged on [DATE]. She said the resident contracted COVID while in the facility and was required to quarantine in her room for ten days, and after that, Hurricane [NAME] affected the city. She said the resident had completed quarantine and was told by facility staff she would be discharged on [DATE]. She said the resident still was unable to leave on 07/09/24 because there was no power at the resident's home. She said then the resident told her she would discharge and go home on 07/13/24. She said she showed up at the facility on 07/13/24 to assist the resident with the discharge process and transportation home. She said when she arrived, the administrator informed her and Resident #2 that the resident was not able to discharge from the facility and needed to wait until 07/15/24. She said she also spoke to Social Worker A over the phone after their conversation with the Administrator. She said Social Worker A reiterated it was unsafe for Resident #2 to discharge on 07/13/24. She said when she spoke to Social Worker A on 07/13/24, she expressed concern about the resident not receiving information about home health agencies and any other assistance the resident may have required, prior to discharge. She said Social Worker A told the Family Member that she was going to be off from work on 07/15/24 but ensured the Family Member home health services were in place, and necessary paperwork, contact information and documentation would be provided to the resident prior to her discharge. She said when she arrived at the facility on the morning of 07/15/24, she was not able to reach Social Worker A over the phone and the Administrator was unavailable. She said the facility handled the resident's discharge inappropriately and unprofessionally. She said a nurse gave the resident a document titled Discharge Plan of Care, but the portion of the document that was supposed to outline the assigned home health agency, contact information and services to be provided was blank. She said a facility nurse and the DON handled the resident's discharge and said they would have to contact Social Worker A for questions. She also said the DON did not want to let the resident leave the facility with her medication. She said the DON told the resident to notify her primary care physician she needed refills on her medication. She said then, the DON contacted someone over the phone and decided it was okay to release the medications. She said the handling of releasing the resident's medications did not seem appropriate either. She said the nurse required the Family Member and the resident to sign portions of the Discharge Plan of Care, even though they all (Family Member, Resident #2, the facility nurse and the DON) were all aware the plan was not accurate or complete. She said the sheet in the Discharge Plan was inaccurate because none of the information pertinent to the resident's discharge was documented. She said the resident never met with staff to develop or discuss her discharge. She said she was still waiting on Social Worker A to return the Family Member's phone call regarding whether home health services were arranged for the resident. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Social Worker A at 07/16/24 at 12:00 PM, she said she held a meeting with the family or the resident at the beginning of their stay. She said no one really knew when a resident's discharge date was going to be. She said on Tuesdays, the IDT team met with corporate and discussed predicted discharge date s for residents. She said the resident may come to her and request any equipment they may need before discharge. She said if the resident was requesting to go home, she would verify if they had chosen a home health agency, if they need certain equipment at home, and if it was ordered. She said after their initial meeting, she did not have a formal meeting or discussion around discharge, unless the family requested. She said there was discharge plan paperwork she completed that covered the home health agency information, any DME and what agency it came from, and the primary care physician if they want to follow up after discharge. She said a lot of times the families wanted to handle those tasks on their own. She said this last week was rather hectic due to the power outages. She said she wanted to ensure safe discharges, and no one went home to be in the heat. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Resident #2 on 07/16/24 at 12:43 PM, she said she was admitted to the facility on [DATE], was supposed to receive six weeks' worth of antibiotic treatment and physical therapy. She said she was alert and a former RN, herself. She said she began asking questions regarding discharge from the moment she was admitted to the facility. She said she wanted to be able to read any literature the facility had available about the discharge process and potential home health agencies, so she could make informed decisions. She said she had grown tired of being in the facility and had asked about discharging prior to her planned discharge date of [DATE], but she decided to stay and complete her treatments. She said on 06/30/24, she tested positive for COVID, and was required to quarantine in her room for ten days. She said toward the end of her quarantine period, she asked the Business Office Manager, Social Worker A, and the Administrator for a discharge notice because she knew her time at the facility was coming to an end. She said she never received a notice, nor did any of the facility staff meet with her prior to 07/15/24 to plan her discharge from the facility. She said even days before her discharge, it was still unclear to her when the facility planned to officially discharge the her. She said since the facility staff still had not communicated with her about her plans for discharge, she decided she was leaving the facility on 07/13/24. She said on the morning of 07/13/24, staff assigned to work with her and the Family Member were all on the same page about the resident discharging. She said she went to the front of the facility to wait for the Family Member's arrival, and she was told by the receptionist, she would not be allowed to discharge from the facility on 07/13/24. She said the Family Member arrived shortly after. She said they spoke to Social Worker A over the phone, and the Administrator who was at the facility at the time. She said Social Worker A and the Administrator told her it was unsafe for her to discharge from the facility and asked her to wait until 07/15/24. She said she asked for discharge paperwork again during both conversations with the Administrator and Social Worker A. She said they both assured her services she required after discharge were handled and paperwork would be provided to her before she discharged on [DATE]. She said when she was ready to discharge on the morning of 07/15/24, a nurse gave the resident a blank document. She said she could not remember who the nurse was. She said the paperwork the nurse gave to her did not provide any of the information she needed. She said she asked the nurse and the DON about home health services, and they told her to get in touch with Social Worker A. She said initially, the DON did not want to release the resident's remaining medication to her. She said the DON told the resident to notify her primary care physician she needed refills on her medication. She said then, the DON contacted someone over the phone and decided it was okay to release the medications. She said even the handling of releasing the resident's medications did not seem appropriate. She said the nurse took a blank sheet of paper, listed the names of the medications and how many of each were being released. She said the nurse required the Family Member and the resident to sign parts of the discharge paperwork. She said she completed her rounds of antibiotics and was evaluated by a physician upon completion. She said she also believed she completed her physical therapy requirements , but was not sure what recommendations, if any needed to be in place now that she was home. She said she had not received any further communication from the facility regarding home health services or any needed assistive devices. In an interview with the Ombudsman on 07/16/24 at 1:42 PM, he said the facility did not follow policies and procedures outlined in the facility's regulatory requirements handbook when they discharged the resident. He said the facility did not provide the resident with a 30-day discharge notice; no care plan meeting for discharge with the resident and an IDT team was held; and the facility failed to notify the Ombudsman Office of the resident's discharge on 07/15/24. He said the resident was discharged to her home, without home health services setup and without the appropriate assistive aids and devices to assist her with ADL's. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER: The Crescent		STREET ADDRESS, CITY, STATE, ZIP CODE: 11353 Sugar Park Lane Sugar Land, TX 77478	

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Social Worker B on 07/17/24 at 2:13 PM, she said she was not sure what was done as far as Resident #2's discharge. She said as of 07/01/24, she was no longer responsible for discharge plans. She said she knew the resident would have been assigned to a home health agency, due to her insurance type. She said however, as far as ensuring services and any other resources the resident would have needed were in place would have been Social Worker A's responsibility. She said she did not know anything about the resident's discharge. She said typically, home health services and any DME equipment needs were set up and confirmed at least one week prior to a resident's discharge date . She said she assumed the resident's services were put in place on 07/16/24 because she received an email from the care coordinator at a home health agency requesting contact information for Social Worker A. She said she forwarded Social Worker A's contact information to the care coordinator but did not inquire with the care coordinator or Social Worker A about the reason her contact information was needed. In an interview with Social Worker A on 07/17/24 at 10:32 AM, she said she was responsible for completing resident discharge plans of care. She said she did not know who was responsible for reviewing discharge plans of care for accuracy. She said she did not know who provided the Administrator with copy of Resident #2's discharge plan of care on 07/16/24. She said after reviewing the discharge plan of care provided to the Administrator on 07/16/24 and reviewing a copy of the plan provided to the resident at the time of her discharge on 07/15/24 were different. She said she recognized the copy of the plan provided to the Administrator had a home health agency along with contact information listed on the first page of the resident's discharge plan. She said she also recognized the second and third pages of the discharge plan given to the Administrator had holes in the top left corner that the first page listing a home health agency did not have in the top left corner. She said she was aware the Administrator was able to produce the first page of a discharge plan of care with Resident #2's demographic information, no home health agency listed, but staple holes in the top left corner that matched the second and third pages of the discharge plan initially provided to the Administrator on 07/16/24. She said the single sheet the Administrator provided with no home health agency information, and staples holes in the top left corner, was the discharge plan of care provided to the resident at the time she discharged . She said she did not know who was responsible for replacing the first page of the plan provided to the resident. She said she did not know why anyone would have switched the documents. She said she did not know who gave the Administrator the wrong discharge plan. She said she was not at the facility at the time the resident left the faciity on [DATE]. She said she was aware Resident #2's discharge plan of care was missing vital information, including home health agency information and other necessary services. She said she did not have an answer for the reason why she did not meet with the resident to discuss discharge plans; why she did not set up and confirm home health services; nor, why she did not ensure the resident's discharge plan of care was accurate and complete prior to ER discharge. She said the resident had been difficult to work with and had changed her mind several times about discharging from the facility. She said she did not think the resident had an unsafe discharge, nor did she think the resident was at risk of anything due to an unsafe discharge. She said even if the Social Worker confirmed home health services were set up for the resident prior to her discharge, the home health agency would not have gone out to see the resident until the next day at home, or once services were approved by the insurance company. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 07/17/24 at 10:40 AM, she said she was not aware home health services had not been arranged for Resident #2 prior to her discharge. She said as far as she knew clinically, the resident was prepared for discharge. She said the resident completed her antibiotic treatment and physical therapy. She said the resident had also been evaluated by the physician and was cleared to discharge. She said residents who did not have a safe discharge from the facility were at risk of re-hospitalization . In an interview with the Administrator on 07/17/24 at 10:48 AM, she said Social Worker A gave her a copy of Resident #2' discharge plan when she requested the document on 07/16/24. She said when it was brought to her attention that the first page of the plan, she received was not the plan of care the resident was discharged from the facility with on 07/15/24, she asked Social Worker A about it. She said Social Worker A then produced a single sheet, which was the first page of the discharge plan of care given to the resident. She said she was unaware a meeting with the Resident #2 to discuss discharge plans did not occur; home health services were not set up and confirmed; nor, did Social Worker A ensure the resident's discharge plan of care was accurate and complete prior to her discharge on 07/15/24. She said even if residents recovered and were well at the time of discharge, the facility needed to ensure any services necessary after discharge were in place, before the resident left the facility. She said failure to ensure a safe discharge put residents at risk of a potential decline in health. She said she spoke with the resident, the resident's Family Member, and Social Worker A on 07/13/24 about the resident discharging on 07/15/24. She said Resident #2's discharge on 07/13/24 would have been unsafe because according to the Family Member, the electricity at Resident #2's apartment had not been restored. She said Social Worker A sent her a text message on 07/13/24 confirming she spoke to the resident. She said she was under the impression all services had already been set up. She said Social Worker A should have held the resident's discharge until her services had been confirmed. She said she could only trust her team to do what they say they have done. She said moving forward, she would get a list of upcoming resident discharges, speak with those residents, contact their physicians and verify additional services and equipment, at random to prevent potential unsafe discharges from occurring in the future. In an interview with the Director of Rehab on 07/17/24 at 11:05 AM, he said within the first couple of weeks, the resident was safely walking from the therapy room down to the gym and walking at her own leisure. He said the facility provided OT while the resident was here to keep her strength up. Their goal was more for restorative maintenance during her stay. He said towards the end of her stay, they were working on balance activities. He said the facility began the process of ordering and necessary DME equipment at the beginning of a resident's stay at the facility. He said because the resident was considered high level functioning, the only thing he recommended was modified independence. He said once the resident was in a standing position, she needed a walker to help her maintain standing and for balance. He said no other recommendations for DME, or additional assistance were made for the resident. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, dated October 2022, titled, Transfer or Discharge, Facility-Initiated revealed the following: Notice of Transfer or Discharge (Planned) 1. Except as specified below, the resident and his or her representative are given a thirty (30)-day advance written notice of an impending transfer or discharge from this facility. 2. The resident and representative are notified in writing of the following information: a. The specific reason for the transfer or discharge .b. The effective date of the transfer or discharge; c. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged .3. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. 4. If information in the notice changes, the facility will update the recipients of the notice as soon as practicable with the new information to ensure that residents and their representatives are aware of and can respond appropriately. 5. For significant changes, such as a change in the transfer or discharge destination, a new notice will be given that clearly describes the change(s) and resets the transfer or discharge date in order to provide 30-day advance notification and permit adequate time for discharge planning . Orientation for Transfer or Discharge (Planned) 1. A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility. 2. A member of the interdisciplinary team will review the final post-discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place .Information Conveyed to Receiving Provider .documentation will include: a) the specific resident needs that cannot be met; b) this facility's attempt to meet those needs; and c) the receiving facility's service(s) that are available to meet those needs; b. Contact information of the practitioner responsible for the care of the resident; c. Resident representative information including contact information; d. Advance directive information; e. All special instructions or precautions for ongoing care, as appropriate such as: (1) treatments and devices (oxygen, implants, IVs, tubes/catheters); (2) transmission-based precautions such as contact, droplet, or airborne; (3) special risks such as risk for falls, elopement, bleeding, or pressure injury; and/or (4) aspiration precautions; f. Comprehensive care plan goals; and g. All other information necessary to meet the resident's needs, including but not limited to: (1) resident status, including baseline and current mental, behavioral, and functional status; (2) recent vital signs; (3) diagnoses and allergies; (4) medications (including when last received); (5) most recent relevant labs, other diagnostic tests, and recent immunizations; (6) a copy of the residents discharge summary; and (7) any other documentation, as applicable, to ensure a safe and effective transition of care. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, revised November 2016, titled, Discharge Summary and Plan revealed the following: When a patient's/resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment. 1. When the facility anticipates a patient's/resident's discharge to a private residence .a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. 2. The discharge summary will include a recapitulation of the patient's/resident's stay at this facility and a final summary of the patient's/resident's status at the time of the discharge in accordance with the established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the patient's/resident's: a. Medically defined condition and prior medical history (medical history before entering the facility and current medical diagnoses, including any history of mental retardation and current mental illness) to include pertinent lab, radiology and consultation; b. Medical status measurement (objective measurements of patient's/resident's physical and mental abilities including, but not limited to, information on vital signs, clinical laboratory values, or diagnostic tests); c. Physical and mental functional status (ability to perform activities of daily living including bathing, dressing, and grooming, transferring and ambulating toilet use, eating, and using speech, language and other communication systems. Includes determining the patient's/resident's need for staff assistance and assistive devices or equipment to maintain or improve functional abilities and the patient's/resident's ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day-to-day activities of the facility); d. Sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence); e. nutritional status and requirements (weight, height, hematological and biochemical assessment, clinical observations of nutrition, nutritional intake, resident eating habits and preferences, and dietary restrictions); f. Special treatments or procedures (treatments and procedures that are not part of basic services provided; for example, treatment for pressure sores, naso-gastric feedings, specialized rehabilitation services, and respiratory care); g. Mental and psychosocial status (patient's/resident's ability to deal with life, interpersonal relationships and goals, make health care decisions, and indicators of resident behavior and mood); h. Discharge potential (the expectation of discharging the resident for the facility within the next three months); i. Dental condition (the condition of the teeth, gums, and other structures of the oral cavity that may affect a patient's/resident's nutritional status, communications abilities, quality of life, and the need for and use of dentures or other dental appliances); j. Activities potential (patient's/resident's ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being. Activity pursuits refer to any activity outside of ADLs which a person pursues in order to obtain a sense of well-being. Includes activities which provide benefits in the areas of self-esteem, pleasure, comfort, health education, creativity, success, and financial or emotional independence, and the patient's/resident's normal everyday routines and lifetime preferences); k. Rehabilitation potential (the ability improve independence in functional status through restorative care programs); l. Cognitive status (patient's/resident's ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and m. Drug therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident) to include reconciliation of all pre-discharge medication with the patient's/resident's post-discharge medication. 3. The post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will contain, as a minimum: a. A description of the resident's and family's preferences for care; b. A description of how the resident and family will access such services; c. A description of how the care should be coordinated if continuing treatment involves multiple caregivers; d. The identity of specific resident needs after discharge (i.e. personal care, sterile dressings, physical therapy, etc.); and e. A description of how the patient's/resident's and family need to prepare for the discharge. 4. The resident or representative (sponsor) should provide the facility with a minimum of a seventy-two (72) hour notice of a discharge to assure that an adequate discharge plan can be developed. 5. The Social Services Department will review the plan with the resident and family twenty-four (24) hours before the discharge is to take place. 6. A copy of the post-discharge plan and summary will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records.

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the undated policy, titled, Nursing Facility Admission Agreement revealed the following: The facility is a licensed long term care facility and does enter into this Nursing Facility Admission and Financial Agreement with the Resident to provide long term care for Resident under the terms and conditions set forth below .17. TRANSFER AND DISCHARGE. If . Except in an emergency, Resident shall not be transferred or discharged without prior consultation with Resident, Resident's Attending Physician and Resident/Resident Representative and written notification describing the reason(s) for the transfer or discharge and Resident's right to appeal the transfer or discharge. Resident may be transferred or discharged if: a. Necessary for Resident's welfare and Resident's needs cannot be met in Facility; b. Resident no longer needs services provided by Facility; c. Resident is endangering the safety of other persons in Facility;