STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chelsea Gardens	4422 Riverstone Blvd Missouri City, TX 77459

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on record review and interview the facility failed to ensure an accurate MDS assessment to reflect the resident's status for 1 of 5 (CR#1) reviewed for MDS assessment accuracy. -The facility failed to ensure CR#1's MDS was updated to accurately reflect her significant change in her weight. This failure placed residents at risk of not receiving care and services to meet the needs of the residents. Findings Included: Record review of CR #'s face sheet revealed she was a [AGE] year-old female that was admitted to the facility on [DATE] with diagnoses of Alzheimer Disease (a progressive disease that destroys memory), cognitive communication deficit (a difficult with communication that is caused by a disruption in cognition), prediabetes, and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Record review of CR#1's admission MDS dated [DATE] revealed: Section C500 -Brief interview of mental status was unscored. Section GG - Functional Abilities and Goals reflected: A. Eating, oral hygiene, toileting, showers, upper and lower body dressing all were coded as 01 (dependent-helper does all the effort). Section K- Swallowing/Nutritional Status revealed Swallowing Disorder was marked as Z. None of the above (loss of liquids, holding food in mouth, coughing, choking, or complaints of difficulty or pain with swallowing). Section I- Nutritional status 152600- Malnutrition had no entry or X for malnutrition risk. Record review revealed no significant change MDS was provided when CR#1 weight went from 87.2 lbs on 7/29/2024 to 71.6 lbs. on 8/28/2024. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676334	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024

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F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Record review of CR#1's discharge MDS dated [DATE] indicated Section GG- Functional abilities had a code change of (2)- which indicated the CR#1 required substantial or maximum assistance to eat (helper does more than half the effort). Section K- Swallowing/Nutrition indicated: Weight Loss was coded (2)- Yes, not on physician prescribed weight loss regiment. Section I- Nutritional status 152600- Malnutrition had no entry or X for malnutrition risk.

Record review of CR#1's care plan dated 7/31/2024 and revised on 8/2/2024 reflected:

CR#1 had a nutritional problem or potential nutritional problem r/t mechanically altered diet, Alzheimer disease, and prediabetes. Goal: CR#1 will maintain adequate nutritional and hydration status weight stable, no signs and symptoms of malnutrition or dehydration through review date of 11/9/2024. Interventions: Administer medications as ordered, monitor and document for side effects of effectiveness. Monitor/document/report PRN any signs and symptoms of dehydration. Monitor/record/report to MD PRN signs and symptoms of malnutrition: Emaciation, muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months and >10% in 6 months.

Record review of weight summary report revealed:

7/29/2024- CR #1 was 87.2 lbs.

8/28/2024- 71.6 lbs.

9/11/2024 - 75.6 lbs.

9/18/2024- 73.8 lbs.

10/7/2024- 70.0 lbs.

During an interview with CR#1's FM on 11/1/2024 at 3:20 p.m. the FM said the facility was responsible for feeding CR#1 but every 2- or 3-days the FM came to visit, and she always asked about food that was still sitting on her table. She said the uneaten food sat well past the mealtimes such as 1 hour after breakfast and sometimes a couple of hours after lunch. She said when she spoke with the CNAs and the nurses, she was told that she had substitutions, but did eat. The FM said she would try to get to the facility for her mealtimes just to observe, but the last few weeks she was unable to get there due to some personal issues. The FM said she took care of CR#1 for [AGE] years and she knew that she would eat if she had to help with the feedings that the facility said they would provide. The FM said staff were supposed to feed her as she was dependent. CR#1 could not feed herself. She stated when she arrived at the facility on 10/17/2024 and saw CR#1's food sitting on her table uneaten. She said staff were mingling near the breakroom so she got very angry and dialed 911 to have her mother sent to the hospital. She said when she was admitted at the local hospital, she was 50 lbs. She said she was severely malnourished and dehydrated. She said she did not recall having more than one care plan meeting, but she mostly called and spoke with the DON or the SSD about her weight. She said she was unaware if the facility had done another care plan to address the weight loss.

(continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the SSD on 11/6/2024 at 10:03am, revealed her to state she had been employed at the facility for 2 years. She said she had been in contact with the family of CR#1. She said she had personally reported to the DON several times that they were concerned about the resident not eating. She said CR#1's FM had been concerned and she witnessed a call between FM and the former DON about placing a peg tube so the resident would get food. She said the former DON questioned the FM about placing her on hospice instead of a peg tube. She said as far she knew the FM was looking into her options of hospice companies around September 2024 sometime. She said the care plan meeting notes she found in PCC was held on 8/8/24 and the FM was not able to attend. She stated care plan meetings are quarterly unless there is a change in condition. She said she does not know why they would not have had another care plan meeting when CR#1 began to lose weight. An interview with the Dietician on 11/6/2024 at 11:45am she said she does rounds at the facility every Thursday. She said after she put in her recommendations for the MD she had to wait on an approval. She said she was not permitted to write any orders. All orders must come from the MD. She said she input recommendations for CR#1 in August 2024. She said she also sent the MD a letter which notified him that she had recommendations that he needed to approve. She said physicians do not always agree with dietician's recommendations and will sometimes make other recommendations. After checking PCC, she said she did not see a response from the doctor. She said she did not follow-up on her recommendation because she normally will not see a resident again for another 60-90 days unless someone at the facility alerts her that an issue has not resolved. An interview on 11/6/2024 at 1:10pm, MDS nurse stated she had been employed since January 2024. She stated she was not aware of CR#1's weight loss prior to her discharge. She stated the MDS assessments were to be completed when a resident was admitted , quarterly, and if there was a discharge. She said she worked remotely and would have to be told by the clinical staff about any changes. She said she would go over the 24-hour report every day. She stated CR #1's weight loss was not noted on the 24-hour report. She said she would not necessarily know about significant changes occurred unless someone bought it to her attention because she was not in the building every day. No one notified her that CR#1 had weight loss. She said the DON would have known about it. She stated the recent update to CR#1's discharge MDS was completed on 10/21/2024. She said she entered the updated information because she assumed she would have returned to the facility. She said she would not have done any updates to the MDS if she knew CR#1 was not returning to the facility . An interview with the Administrator on 11/8/2024 at 12:50pm, he stated it was the dietician's responsibility to review residents' weights weekly. He said each week she checked in on the residents and when there was weight loss it should be documented in PCC and then it was the MDS nurses' responsibility to ensure that the MDS and care plans were updated. He said he was not sure why a significant change MDS was not updated. Record review of the facility's change in condition policy revised in February 2021 stated it is the facility's policy to promptly notify the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. 9. If a significant change in the resident's physical condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI Instruction manual. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of MDS Nurse job description revealed the position summary: Responsible for the coordination, scheduling and submitted of the resident's clinical assessments Minimum Data Set (MDS) as required by state and federal regulations as well as other third-party payers. This position reports to the DON.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on interviews and record review the facility failed to maintain acceptable parameters of nutritional status in such as usual body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicate otherwise for 1 of 5 (CR#1) residents reviewed for weight loss. -The facility failed to ensure CR#1 was monitored for weight loss resulting in a 19.7% or 17.2 lbs. in 3-month period. CR#1 was admitted to hospital with hypernatremia and generalized weakness and a 43-pound weight loss since her last hospitalization . -The facility failed to ensure CR#1 maintained acceptable parameters of nutritional status such as her usual body weight. CR#1 was admitted to hospital with hypernatremia and generalized weakness and a 43-pound weight loss since her last hospitalization -The facility failed to implement dietary recommendations. An Immediate Jeopardy (IJ) was identified on 11/8/2024 at 3:18 p.m. The IJ template was provided to the facility on [DATE] at 3:18pm, While the IJ was removed on 11/13/2024 at 3:29 p.m., the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm the facility continued to monitor the implementation and effectiveness of their corrective systems. Finding included: Record review of CR #1's face sheet revealed she was a [AGE] year-old female that was admitted to the facility on [DATE] with diagnoses of Alzheimer Disease (a progressive disease that destroys memory), cognitive communication deficit (a difficult with communication that is caused by a disruption in cognition), prediabetes, and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). Record review of CR#1's MDS dated [DATE] revealed: Section C500 -Brief interview of mental status was unscored. Section GG - Functional Abilities and Goals reflected: A. Eating, oral hygiene, toileting, showers, upper and lower body dressing all were coded as 01 (dependent-helper does all the effort). Section K- Swallowing/Nutritional Status revealed Swallowing Disorder was marked as Z. None of the above (loss of liquids, holding food in mouth, coughing, or choking or complaints of difficulty or pain with swallowing). Section I- Nutritional status 152600- Malnutrition had no entry or X for malnutrition risk. Record review revealed no significant change MDS was provided when CR#1's weight went from 87.2 lbs on 7/29/2024 to 71.6 lbs. on 8/28/2024. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's discharge MDS dated [DATE] indicated Section GG- Functional abilities had a code change of (2)- which indicated the CR#1 required substantial or maximum assistance to eat (helper does more than half the effort). Section K- Swallowing/Nutrition indicated: Weight Loss a code of (2)- Yes, not on physician prescribed weight loss regiment. Section I- Nutritional status 152600- Malnutrition had no entry or X for malnutrition risk. Record review of CR#1's care plan dated 7/31/2024 and revised on 8/2/2024 reflected: CR#1 had a nutritional problem or potential nutritional problem r/t mechanically altered diet, Alzheimer disease, and prediabetes. Goal: CR#1 will maintain adequate nutritional and hydration status weight stable, no signs and symptoms of malnutrition or dehydration through review date of 11/9/2024. Interventions: Administer medications as ordered, monitor and document for side effects of effectiveness. Monitor/document/report PRN any signs and symptoms of dehydration. Monitor/record/report to MD PRN signs and symptoms of malnutrition: Emaciation, muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months and >10% in 6 months. Record review of weight summary report revealed: 7/29/2024- CR #1 was 87.2 lbs. 8/28/2024- 71.6 lbs. 9/11/2024 - 75.6 lbs. 9/18/2024- 73.8 lbs. 10/7/2024- 70.0 lbs. Record review of dietician progress notes revealed on 8/1/2024: CR#1 estimated energy need was 1750 kcal, 65 grams of protein, fluids 1500 ml. CR#1 is 88% of DBW (desirable body weight) with poor intake. During RD rounds, a physical assessment was conducted. CR#1 was very thin stature, muscle wasting, as well as orbital subcutaneous fat wasting and appears to have a nutritional deficit. Resident is supplemented with Zinc and Vitamin C but may benefit from additional nutrients to support wound healing and weight repletion. CR#1 has a potential for desirable weight gain, weight fluctuation, and dehydration. Recommendation: 1. 2k cal house supplement, 90 ml TID after meals to promote weight repletion and maintenance, 2. Liquid protein 30ml BID for 90 days to support muscle mass and wound healing; (3) Juven/Arginaid plus 8 oz H20 BID for 30 days. Goal: Weight maintenance or steady weight gain of +4% by next review date. Will monitor clinical status, weights, labs intakes and skin. Record review of CR#1's MAR revealed: July 1-31, 2024- Thiamine HCI 50mg 1 time daily ordered, Rivastigmine/Patch 4.6mg/24-hour, Vitamin B 50 mg 1 time daily, Zinc Oral tablet 50 mg 1 time per day, Lidocaine patch 4% for pain, Lovastatin 40 mg daily, Aspirin 81mg 1 time daily, Acetaminophen 325 for pain every 6 hours and PRN, Ascorbic Acid 500 mg 1 time daily. August 1-31, 2024- all medications remained the same. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	September 1-31st - Thiamine HCI 50mg 1 time daily ordered, Rivastigmine/Patch 4.6mg/24-hour, Vitamin B 50 mg 1 time daily, Zinc Oral tablet 50 mg 1 time per day, Lidocaine patch 4% for pain, Lovastatin 40 mg daily, Aspirin 81mg 1 time daily, Acetaminophen 325 for pain every 6 hours and PRN, Ascorbic Acid 500 mg 1 time daily. Additional medications added in September were Ativan Oral Tablet 0.5 was ordered on 9/13/2024 and discontinued on 9/22/2024, Bisacodyl Rectal suppository 10 mg daily beginning 9/13/2024, Morphine Sulfate 20 mg and Promethazine 25mg daily for nausea. October 1-17, 2024- there were no new medications from [DATE] medication list. Record review of nursing progress notes revealed there were no progress notes indicating CR#1's weights were trending downward between 7/29/2024-10/7/2024. Record review of hospital admission paperwork revealed CR#1 was admitted to a local hospital on 10/17/2024. The principle or chief problem for admission was hypernatremia and generalized weakness. CR#1's weight upon admission was 55 lbs. and she was severely dehydrated. The recorded weights for CR#1's last three encounters at this local hospital were: 10/18/2024- 24.9 kg (55lbs) 7/26/2024 - 44.6 kg (98 lbs 6.4 oz) 2/16/2024 - 44 kg (97 lbs.) An interview with RN A on 11/1/2024 at 10:56a.m., revealed her to state she had been employed at the facility for 7 months. She said all of the nurses work different halls every shift. For example, one day she might be the nurse on Halls 100 and 200 and the next day 200 and 300 and so on. She said she did not work on the hall where CR#1 resided very often. She said she recalled CR#1 had a regular diet with puree texture and thickened liquids. She said her legs were contracted to her abdominal area (fetal position contracture). She said this made it dfifficult to tell she had loss weight. She denied being alerted by staff of CR#1's refusals to eat, loss of weight or other concerns. She said CR#1 liked sweets so if they added pudding to her food she would normally eat. She said she might not have eaten what was cooked for her, but she did eat. She looked in PCC and stated she did not see any nursing notes concerning her intake for the month of October, 2024. She said she would have documented any refusals and had the CNA's get her a substitution if she refused her meal. She stated if a resident does not eat, they will not get their daily nutritional and hydration needs met. She said she was not sure why CR#1 was losing weight. An interview with RN C at 11:17 a.m., revealed she had been employed for 3 months. She was responsible for halls 300 and 400 today. She said the other nurse is responsible for Halls 100 and 200 and the nurses usually worked 6am-6pm. She said there were 3 CNa's on the halls. She said she worked 10am-6pm shift. She said she was not too familiar with CR#1 and do not recall being told that CR#1 was not eating or refusing meals. She stated she would have alerted the interim DON, Administrator, Physician and family about the issue. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with CNA A on 11/1/2024 at 12:32 p.m. revealed CR#1 needed assistance with feedings. He said she had a pureed diet and preferred to eat in her room. CNA A stated CR#1 often did not want to eat as she would not open her mouth when staff put the spoon to her mouth. Further, that he would alert the on-duty nurse anytime she did not eat. He said he cannot recall how often she refused to eat. He said he documented refusals but always offered her a substitute. He said she liked applesauce and pudding. He stated CNA B was the lead CNA and she could usually get her to eat her meals. She was familiar with her from another facility. He said she did not refuse other ADL's such as brief changes and bed baths. During an interview with CR#1's FM on 11/1/2024 at 3:20 p.m. the FM said the facility was responsible for feeding CR#1 but every 2- or 3-days the FM came to visit, and she always asked about food that was still sitting on her table. She said the uneaten food sat well past the mealtimes such as 1 hour after breakfast and sometimes a couple of hours after lunch. She said when she spoke with the CNAs and nurses, she was told that she had substitutions, but did eat. The FM said she would try to get to the facility for her mealtimes just to observe, but the last few weeks she was unable to get there due to some personal issues. The FM said she took care of CR#1 for [AGE] years and she knew that she would eat if she had help with feedings that the facility said they would provide. The FM said staff were supposed to feed her as she was dependent. CR#1 could not feed herself. The FM said she spoke to the Social Services Director on several occasions to address the issue. She said she had only spoken to the DON once about CR#1 food intake and staff not feeding her but the DON never followed-up with her about it. Instead, the SSD became her point of contact as she learned that the DON was no longer employed at the facility since September 2024. The FM asked SSD about a feeding tube during a telephone care plan meeting. She said she told the SSD that she would also start researching peg tube feedings because she did not know the difference between a peg tube or g-tube and how it would affect a resident her age. The FM said she wanted CR#1 to eat or be fed by any means possible. The FM said during a visit on 10/17/2024, CR#1 was lethargic and appeared to be severely malnourished. The FM said she could tell by looking at CR#1 that she had loss more weight since she saw a few weeks ago. The FM said once again her lunch was still sitting on her table uneaten. She said she observed CNA A and nurses near their breakroom, and it infuriated her that staff were standing around while CR#1 had not been fed. She called 911 and had CR#1 sent to the ER at a local hospital. The FM said upon arrival at the ER she was told CR#1 was severely dehydrated. The FM said a nurse at the hospital stated due to the muscle wasting, and lethargic state it appeared that CR#1 had not eaten or had been given enough water in weeks. An interview with Tray Aide on 11/6/2024 at 9:40am, she stated he had been employed since [DATE]. She said the CNAs hand out trays, pick up trays, and pushcart back to the kitchen. She said CNAs were supposed to input how much the residents were eating. She can recall trays coming back with uneaten food for CR#1. She said some of the food would be eaten but the meat was mostly what she would not eat. She said the pureed bananas and applesauce were always eaten. She said anytime she saw her tray with uneaten food she would inform the Dietary manager. She said she was not responsible for documenting food intake. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the SSD on 11/6/2024 at 10:03am, revealed her to state she had been employed at the facility for 2 years. She said she had been in contact with the family of CR#1. She said she had personally reported to the DON several times that they were concerned about the resident not eating. She said CR#1's FM had been concerned and she witnessed a call between FM and the former DON about placing a peg tube so the resident would get food. She said the former DON questioned the FM about placing her on hospice instead of a peg tube. She said as far she knew the FM was looking into her options of hospice companies around September 2024 sometime. She said the care plan meeting notes she found in PCC was held on 8/8/24 and the FM was not able to attend. She stated care plan meetings are quarterly unless there is a change in condition. She said she does not know why they would not have had another care plan meeting when CR#1 began to lose weight. An interview with the Dietician on 11/6/2024 at 11:45am she said she did rounds at the facility every Thursday. She said after she put in her recommendations for the MD she had to wait on an approval. She said she was not permitted to write any orders. All orders must come from the MD. She said she input recommendations for CR#1 in August 2024. She said she also sent the MD a letter which notified him that she had recommendations that he needed to approve. She said physicians do not always agree with dietician's recommendations and will sometimes make other recommendations. After checking PCC, she said she did not see a response from the doctor. She said she did not follow-up on her recommendations because she normally will not see a resident again for another 60-92 days unless someone at the facility alerts her that the issue has not resolved. During a telephone interview with the Dietary Manager on 11/6/2024 at 1:32pm, she said she had been employed at the facility for 4 to 5 years. She said CR#1 had a pureed diet, thickened liquids, and had to be fed. CR#1 ate in her room. She stated that the Dietician told her one time that CR#1 was not eating her food. She said it was the responsibility of the Dietician to put recommendations in place for residents when they were not eating. She said it was placed on the dietary notes. She said if a tray came back, and food was not eaten, the tray aide would notify the nurse. She did not recall being told any other time about CR#1 not eating. She said they gave her yogurt and pudding because she would eat sweets. The State Investigator asked if she was responsible for documenting residents food intake. She said, No. She said she was not feeling well, and the call ended. An interview with the Administrator on 11/6/2024 at 1:42pm, revealed he called the Dietary Manager about documentation she had concerning CR#1 meals/intake. He said the Dietary Manager was out sick, but she had documentation she kept on a Word document that she would send him today. He admitted that he did not see any nursing progress notes or plan of care notes (POC) by the CNAs that documented refusals or her food intake. He stated that he conducted a performance improvement plan (PIP) when he was emailed by CR#1's FM on 10/18/2024. He said after the incident the DON, dietary, housekeeping, and even therapy would be keeping an eye out to ensure every resident gets a tray and let the nurse know when they refuse. He said the CNAs or nurse might miss sometimes but others will be able to see and notify nurses on the floor when residents were not eating . He said this failure could cause residents obvious weight loss, nutritional needs not being met and not enough hydration. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A telephone interview with 11/6/2024 the facility MD at 3:41pm revealed that CR#1 was losing weight and the family declined a peg tube as far as he could recall. The State Investigator asked if he had been told that the FM had found uneaten trays of food on many occasions as she was not being fed. He said he was not aware of staff being unable to feed her nor of any refusals to eat. He denied receiving any recommendations from the dietician. He stated his NP would have more information as he was at the facility weekly, and he would have to follow-up with him on this patient. He stated the protocol was to ensure there was a dietician consultant when there was weight loss for recommendations, medications, and overall patient care being addressed. He stated he could not recall any IDT meeting concerning CR#1 weight. He did not mention failure to thrive as a diagnosis that was causing CR#1's weight loss. In a subsequent interview with the MD on 11/6/2024 at 3:50pm, he stated that he had orders for supplements and the dietician recommendations were in the system. However, they were showing that CR#1 was on hospice. He said she was enrolled, and Hospice was involved in her care. He said he would have his NP reach out to me. In an interview with local Hospice representative on 11/8/2024 at 12:25pm, Rep stated CR#1 was on services from 9/13/2024-9/16/2024. In a subsequent interview with the Administrator on 11/8/2024 at 12:50pm, he stated it was the dietician's responsibility to review residents' weights weekly. He said each week she checked in on residents and when there was weight loss it should be documented in PCC. The recommendation from the dietician for CR#1 on 8/1/2024 should have been communicated to the physician or NP, they should have either approved, denied it, or made other recommendations. The orders were carried out by nursing. He said, the Dietician should have checked to see if it was approved or denied, and she could have also checked to see if the MD had ordered anything. He said when she came back the following week, she might have had to make other recommendations. He said it looked like CR#1's recommendations got missed somehow. He said the FM denied a peg tube before and after admission. He stated he can recall two occasions or meetings that was discussed with her FM that she was eating but not enough food and having weight loss. He said he was unable to find documentation for the recommendation for a peg tube. He stated that the MD had faxed him a letter which stated that CR#1 had experienced weight loss due to her dementia and failure to thrive. The State Investigator stated the MD did not mention that CR#1 had an additional diagnosis of failure to thrive, she was not admitted with this diagnosis, it was not listed on her face sheet, hospital admission paperwork, care plan, nor anywhere else. He stated, Well that is what the MD stated on the letter. He added that it was the facility's policy concerning residents that were not eating to talk to the family, offer other food alternatives, and come up with other substitutions that they were willing to eat. He said communication with the family and the physician was important. He said sometimes the MD might order different stimulants to increase their appetite or provide other medications. He stated the kitchen staff were willing to make other food for the residents. He said if staff saw CR#1 had not eaten they would have said something to the nursing staff. CR#1 was declining and a very sick resident. He said it was the family's decision not to have a peg tube placed, because she would not be able to have food by mouth . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676334	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chelsea Gardens	4422 Riverstone Blvd Missouri City, TX 77459

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with CNA B on 11/8/2024 at 1:28 p.m., she stated she had been employed here since 2017. She was the CNA lead and central supply. She said she knew CR#1 from a previous facility. She said she was very surprised when she saw her here in July. She said she was admitted here with contractures and not walking. She said she wanted to sleep a lot. She said the FM asked her to take a picture when she ate her food and send her a picture when she worked. She said the resident ate a lot of mashed bananas, yogurt, and applesauce. She said she mentioned her weight loss to the Dietary Manager, and she said the dietician had put her on supplements. The FM bought Boost when she was admitted , but she did not recall if CR#1 drank them but she did not see any more after she was admitted . She said CR#1 ate but sometimes only 50% or less. She said she mentioned to the DON that she was losing weight. She took her weight a few times and notated the decline. She stated before she left her shift, she would always double back to see if CR#1 ate and if not try to feed her. She said she would leave the extra bottled water, thickened juice, and applesauce. In an interview with NP on 11/11/2024 at 3:26 p.m. he took out his tablet and stated CR#1 was admitted on [DATE] and on 8/1/2024. He was notified that she had poor NPO intake, so the dietician recommended house supplements, and liquid protein Juven to promote wound healing. He stated he did not see anywhere in PCC that he had placed an order or approved her recommendations. He said he was unsure of what happened. He said if there was an order, he could no longer see it in PCC. He stated he came to the facility every Monday. He also asked the nurses if anything was going on with residents that he needed to know about. No one ever told him about her severe weight loss. He stated he noticed the weight change for CR#1 upon a visit and he recommended Hospice care on 8/21/2024. The State Investigator informed him that CR#1 was taken off Hospice only a few days after being enrolled on 9/13/2024. He said he did not know she was taken off hospice. The hospice order was still active in the system, so he assumed she was still on hospice. He said when patients are on hospice services, they normally take provide life care and comfort measures. He said weight loss was usually followed up with a peg tube or hospice care. He said there was no documentation here at this facility about hospice care. He said he could see the weights in PCC, but not her food intake. He said sometimes in cases like this with severe weight loss, supplements, or a medication called Remeron or stimulant Megace, was effective but sometimes patients run into insurance not paying for it plus they cannot be on it for long periods of time due to the side effects. He stated CR#1 was put on hospice and that was why he would not see her. He said there were no nursing notes hardly and nothing mentioned about hospice being stopped. If he had been notified, he would have called the family himself and gave them the option of the medication for her appetite or a peg tube. Record review of weight monitoring policy revised on August 2024 revealed based on a resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status such as usual body weight or desirable body weight range and electrolyte balance. Guidelines: Weight can be a useful indictor of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. 1. The facility will utilize systemic approaches to optimize a resident's nutritional status. This process includes a. Identifying and assessing each resident's nutritional status; b. evaluating and analyzing the assessment information; c. Developing and consistently implementing pertinent approaches; d. Monitoring the effectiveness of interventions and revising them as necessary. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Chelsea Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE: 4422 Riverstone Blvd, Missouri City, TX 77459	

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Interventions will be identified, implemented, monitored, consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards to maintain acceptable parameters of nutritional status. 5. A weight monitoring schedule will be developed upon admission for all residents: c. Residents with weight loss- monitor weight weekly. 7. Documentation: A. The physician should be informed of a significant change in weight and may order nutritional interventions; B. The physician should be encouraged to document the diagnosis or clinical condition that may be contributing to the weight loss; C. Meal consumption information should be recorded and may referenced by the Interdisciplinary team. E. The dietician and dietary manager should be consulted to assist with interventions; actions are recorded in the nutritional progress note. This was determined to be an Immediate Jeopardy (IJ) on 11/8/2024 at 3:18pm. The administrator was notified. The Administrator was provided with the IJ template at that time via email. The following Plan of Removal was submitted by the facility on 11/8/2024 and approved on 11/9/2024 at 5:55pm: Failure: F-692 Nutrition/Hydration status maintenance The facility failed to ensure CR#1 was monitored for weight loss resulting in a 19.7% or 17.2 lbs. in less than 3-month period. The facility failed to ensure CR#1 maintained acceptable parameters of nutritional status such as her usual body weight of 90 lbs. The facility failed to ensure CR#1 was offered sufficient fluids to maintain proper hydration. She was admitted to a local hospital severely dehydrated on 10/17/2024. 1. Identification of Residents Affected or Likely to be Affected: Include actions that were performed to address the citation for recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the facility's noncompliance and the date the corrective actions were completed. (Completion Date: 9 [DATE]) Patient CR#1 is no longer at the facility D/C 17 [DATE] All patients in the building were evaluated for weight loss. Completed by the interim DON. 6 patients are on our weight loss watchlist. Dehydration Risk Assessments have been completed. 2. Actions to Prevent Occurrence/Recurrence: Include actions the facility will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, by whom and when those actions were completed. (Completion Date: 9 [DATE]) (continued on next page)

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