STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676362	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgecrest Rehabilitation Suites	14100 Karissa Court Houston, TX 77049

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on, interview and record review the facility failed to ensure that residents transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. The facility failed to develop and implement an effective discharge planning process that focused on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care and the reduction of factors leading to preventable readmissions for 1 of 1 resident (CR #1) reviewed for inappropriate discharges - The facility failed to develop a complete and accurate discharge summary/plan for CR #1's discharge on [DATE].- The facility failed to order necessary equipment (a hospital bed) for CR #1's discharge on [DATE].- The facility failed to provide CR #1's clinical information to the receiving personal care home when she was discharged on 01/23/26. These failures could place residents at risk of not having complete records, necessary services, or information after permanent discharge from the facility. Findings include: Record review of CR #1's Face Sheet dated 02/04/26 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: pressure ulcers, bladder infection, acid reflux, diabetes with neuropathy (nerve damage causing tingling, burning pain and muscle weakness), high blood pressure, generalized muscle weakness and other abnormality of gait (how a person walks) and mobility. CR #1 discharged from the facility on 01/23/26 at 11:16 AM. Record review of CR #1's MDS dated [DATE] revealed, CR #1 admitted after a short-term hospital stay, moderately impaired cognition as indicated by a BIMS score of 11 out of 15, lower extremity functional limitations in range of motion on both sides. Total dependence on helper for lower body dressing, putting on/taking off footwear, toileting, moving from: sit to lying, lying to sitting on side of bed, sit to stand and chair to bed transfer. CR #1 used a manual wheelchair, was totally dependent on helper to wheel 50 feet with two turns or wheel 150 ft and was always incontinent of both bladder and bowel. Record review of CR #1's undated care plan revealed, problem: Neuropathy and is at risk for increased pain d/t impaired cognition and impaired mobility; Approach: Pharmacological interventions as ordered by the provider. Consider factors such as causes,location, and severity of the pain, the potential benefits, risks and adverse consequences of medications, and the resident's desired level of relief and tolerance for adverse consequences. Problem: required assistance to complete ADL tasks d/t impaired cognition, impaired mobility and incontinence; Problems- Transfers- Assist of 2 utilizing a [Mechanical Lift] a device used to safely transfer individuals with limited mobility between a bed, wheelchair, or toilet), Wheelchair for mobility, and bed mobility- Assist of 1. Record review of CR #1's Progress Notes from 12/30/25 to 01/23/26 revealed:- 01/17/26 at 02:29 PM signed by LVN B, Resident continued on skilled services with NAD noted or complaints voiced. Resident able to make needs known and required a [Mechanical Lift] for transfers due to paraplegia. - 01/19/26 at 12:04 PM signed by the former social worker, Resident has remained on skilled (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services for both PT and OT services.Resident requires assistance with lower body tasks such as dressing and toileting. Resident for these skills is maximum assistance. Resident is able to complete task for upper body. Friday January 16,25 former Home health came to visit and has offered to assist her again upon her discharge. Social Worker was unable to reach family at that time in regard to discharge as resident had previously indicated her desire to go to another facility however at the present she is not meeting all criteria for medical necessity.I had shared this with resident and shared with her about option of a personal care home which she had said she would think about. Have left message [placement coordinator] to contact me. Will follow up with resident and the home health and also her family. Resident has not yet received a NOMNC.- 01/23/202611:13 AM signed LVN A, Resident discharged at this time to home care facility--Accompanied by facility van driver -Discharge information and medications sent with Resident/driver -Resident verbalized understanding of medication administration--Resident stable at the time of departure. -01/26/26 at 10:08 AM signed by the former social worker, Resident records were sent to [Home Health] week before resident was discharged on Friday on Friday the 23rd . They are to follow personal care home in the community. Medication list is sent to [Home Health] at this time. Resident is residing at personal care at this time. Will follow up with [Home Health]as to when they will be able to see resident in the community. Records to be sent to physician in the community and make him aware resident as resident is in the personal care home as well.There was no documentation that the facility sent records to the location the facility delivered CR #1 to upon discharge on [DATE], Personal Care Home, no documentation of an order for DME (hospital bed), and no documentation of coordination of home health services. Record review of CR #1's Joint Mobility Screen dated 12/31/25 revealed, movement of CR #1's lower body could not be assessed but she had full mobility of her upper body. Record review of CR #1's OT Discharge Summary for dates of service 12/30/2025 - 1/21/2026 revealed, at time of discharge CR #1 required Maximum Assistance with: dressing, toileting, and lower body bathing. Discharge recommendation: Home health services. Record review of CR #1's discharge documents revealed, the document was faxed on 01/29/26 at 02:58 PM (6 days after CR #1 discharged from the facility on 01/23/26). The document included:- a signed receipt of medication upon discharge form issued on 01/23/26.- continuity of care document which provided the CR #1's: emergency contact information and next of kin, medication list and dates the medications were last administered, diagnoses, insurance information, recent labs, care plan, social history.- Transition of Care/Discharge summary dated [DATE] at 10:47 AM signed by LVN A with the physical functioning and structural problems addressing Mobility Devices, Self-Care and Mobility left blank in the Clinical Discharge and Narrative section.The document did not indicate necessary equipment[Mechanical Lift], or services CR #1 would require upon discharge. Record review of CR #1's Discharge summary dated [DATE] revealed, -The physical functioning and structural problems addressing Mobility Devices, Self-Care and Mobility were all left blank in the Clinical Discharge and Narrative section.- The Care Team section was left blank.- The Scheduled Appointments was left blank.- The Special Instructions section addressing dietary/nutrition and therapy were left blank.- The Medical Equipment section was left blank.- The Continence section was left blank.- The Customary Routine section was left blank.There was no documentation of the address CR #1 would be discharged to. Record review of the facility's undated Internal Investigation completed by the Administrator revealed, 01/24/26- Administrator later received phone call from [Personal Care Homeowner Owner] states that she did not receive any clinical information from the SW like she had requested. Owner states that she CR #1 could transfer herself and did not need a hospital bed which was incorrect. Administrator checked Matrix for social service progress notes. No documented notes of SW setting up DME and HH. Administrator (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempted to call SW however she did not answer. Left message requesting a call back. Administrator went on [portal] and ordered hospital bed for residents. Administrator telephoned [Owner] and informed her of ordering a hospital bed. Administrator stated she would continue to update as she received information.01/26/26- Administrator met with SW re: discharge of resident. SW admitted to not ordering DME stating she was told that residents did not need any. She also stated that she did not fax referral for home health. Administrator ordered SW to make HH referral immediately and it was completed. During verbal counseling, SW decided to issue resignation. Administrator later received notification that [DME company] would not be able to fulfill DME order. Administrator made referral for [DME company] DME. That afternoon resident's [Family Member] came to facility and resident requested via phone a copy of medical records for PCH to be given to her. Once she received medical records, she left the facility. In an interview on 02/04/26 at 10:11 AM, the Administrator said CR #1 required maximum assistance for transfers, she had good upper body strength but had a paraplegic lower body. She said after CR #1 discharged , she received a call from the personal care home, who stated the necessary equipment (hospital bed) had not arrived. The administrator said she submitted the order for the hospital bed to the DME company and sent the required clinicals to the personal care home but there were issues with CR #1's insurance which resulted in delay until 01/29/26. She said the Social Worker was responsible for CR #1's discharge on [DATE] but she was no longer employed at the facility. In an interview on 02/04/26 at 10:47 AM, CR #1's family member said, the facility failed to communicate CR #1's lower extremity functional limitations to the admitting facility or order a hospital bed when she discharged to the personal care home on [DATE]. She said the facility CR #1 was transferred to only had a twin bed and did not know the resident could not transfer herself. An attempt was made on 02/04/26 at 11:44 AM to contact the Social Worker by telephone. The number provided by the facility was not in service. In an interview on 02/04/26 at 12:03 PM, The Owner of personal care home said, prior to CR #1's arrival in the facility the former Social Worker failed to send any clinical records on CR #1 and failed to verbally communicate that the resident required maximum assistance or a hospital bed. The Owner of the personal care home said when CR #1 arrived at the facility the home did not have the hospital bed CR #1 required due to her inability to use her legs. She said her facility could not meet CR #1's needs and could not meet the needs of immobile residents that required maximum assistance because they did not have sufficient staff to transfer the resident. In an interview on 02/04/26 at 12:44 PM, the Transportation Staff said, on 01/23/26 she transported CR #1 to Personal Care Home B. She said when she arrived at the care home, CR #1's room did not have a hospital bed, there was a regular twin bed Kids twin bed low to the ground in the room. The Transportation Staff said the personal care home did not have sufficient staff to transfer CR #1 when she arrived so she had to help transfer the resident to her new bed. In an interview on 02/04/26 at 01:06 PM, the PTA said CR #1 required maximum assistance for bed mobility, and sitting up or turning in bed so she would need an adjustable bed to sit up independently. In an interview on 02/04/26 at 01:50 PM, the Administrator said there was no documentation to support the facility sent CR #1's clinical records to the personal care home, or DME orders were submitted prior to CR #1's discharge on [DATE]. She said facility staff are expected to initiate discharge planning at admission and all services should be initiated prior to discharge. The Administrator said the personal care home was not notified of required DME prior to CR #1's arrival. She said the Social Worker was responsible for making sure the discharge facility was appropriate, supplies were available and clinicals were sent but failed to do so. The Administrator said resident's discharge summary should include the name and address of the discharge facility and the information was missing from CR #1's discharge summary. She said (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	based on her review CR #1's discharge summary was incomplete as it did not include where she was going, services or equipment needed or appointments needed post discharge. The Administrator said the Social Worker separated her employment due to this incident but the investigation revealed, clinical information was never sent to the personal care home. The Administrator said failure to develop a complete and accurate discharge plan/summary could place residents at risk of missed care and an inappropriate discharge that is neither successful nor safe. Record review of the facility policy titled Admission, Discharge and Transfer- Code of Ethics revised 10/23/19 revealed, 15- All aspects of transfer and discharge are documented in the medical record, including A- patient/resident and/or family notification. B- Attending physician's written or faxed orders. 18- Sufficient preparation and orientation to the patient/resident are provided for a safe and orderly transfer or discharge. The policy did not provide further details on coordinating safe and orderly transfers for Residents.