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	05/03/2024

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572 Based on observation, interview and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for two of eighteen residents (Resident #27 and Resident #41) reviewed for safe, clean, homelike environment. -The facility failed to clean enteral feeding pumps and poles, which were dirty on 4/30/2024, 5/1/2024, and 5/2/2024 for Resident #27 and #41. -The facility failed to ensure the rooms were homelike and did not have peeling paint and well-maintained bedside tables on 4/30/2024, 5/1/2024, and 5/2/2024 for Resident #27 and Resident #41. This failure could affect the residents and place them at risk of an unsafe and an environment that was not homelike. Findings include: Resident #27 Record review of Resident #27's face sheet dated 5/2/2024 revealed a [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included dementia (group of symptoms that affects memory, thinking and interferes with daily life), contractures (permanent shortening of muscles, tendons, skin, and nearby soft tissue that causes joints to shorten and stiffen, preventing normal movement), seizures (sudden, uncontrolled burst of electrical activity in the brain), anxiety disorder (condition with exaggerated tension, worrying, and nervousness about daily life events), gastronomy (surgical procedure for inserting a tube through the abdomen wall into the stomach), GERD (Gastroesophageal Reflux Disease, chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, the tube connecting the mouth and stomach), and adult failure to thrive (significant decline in physical and/or emotional well-being). (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #27's quarterly MDS dated [DATE] with an ARD of 4/15/2024 revealed no BIMS could be conducted because she was rarely or never understood. The MDS documented she had short and long-term memory problems, and she was severely impaired in her ability to make decisions regarding tasks of daily living. Per the MDS, Resident #27 was unable to recall the current season, the location of her room, staff names and/or faces, or that she was in a nursing home. The MDS revealed she had impairments of both upper and lower extremities, and she utilized a wheelchair for mobility. The MDS documented she required extensive assistance, or was totally dependent on staff, for all ADL's except eating. Per the MDS, Resident #27, did not eat. The MDS revealed she was fed via feeding tube, and she received 51% or more of her nutrition and 501cc of fluids daily through the tube. The MDS documented she received OT and ST services. Record review of Resident #27's care plan dated 4/17/2024 revealed a focus on her feeding tube use with interventions including cleaning site with normal saline, patting it dry, and leaving it open to air. The care plan documented a focus on her dementia with interventions including having her needs met by staff. Observation on 4/30/2024 at 9:39 AM of Resident #27 revealed she was lying in her bed on an air mattress. Resident #27 was receiving nutrition via feeding tube at 50ml/hr. Resident #27 had contractures visible of both upper extremities. The room's floor appeared clean, but the walls had peeling and missing paint, the base of the apparatus holding the feeding tube, the electronic monitor for the feeding tube, and the bags of nutrition and hydration had a rust-colored substance on all four wheelbases. Observation on 5/2/2024 at 1:02 PM revealed the walls of Resident #27's room were missing paint and peeling. The base of the apparatus holding her feeding tube, electronic monitor for the feeding tube, and bags of hydration and nutrition had a rust-colored substance on all four wheelbases. Resident #41 Record review of Resident #41's face sheet dated 5/3/2024 revealed an [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included osteomyelitis (infection in the bone caused by bacteria or fungi), gastronomy status (surgical procedure for inserting a tube through the abdomen wall into the stomach), disorientation (altered mental state with loss of sense of time, identity, direction, and place), contractures (permanent shortening of muscles, tendons, skin, and nearby soft tissue that causes joints to shorten and stiffen, preventing normal movement), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #41's quarterly MDS dated [DATE] with an ARD of 4/8/2024 revealed no BIMS was conducted because she was rarely or never understood. The MDS documented she had short and long-term memory problems, and she was severely impaired in her ability to make decisions regarding tasks of daily living. Per the MDS, Resident #41 was unable to recall the current season, the location of her room, staff names and/or faces, or that she was in a nursing home. The MDS revealed she had an impairment of one upper and one lower extremity, and she used a wheelchair for mobility. The MDS documented she totally dependent, or required extensive assistance, with all ADL's except eating. Per the MDS, Resident #41 did not eat during the review period. Per the MDS, resident #41 used a feeding tube, and she received 51% or more of her nutrition and 501cc's or more daily through the feeding tube. The MDS revealed she received PT services. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of resident #41's care plan dated 3/20/2024 revealed a focus on her GERD with interventions including diet as ordered and raising the head of her bed as tolerated. The care plan documented a focus on her possible malnutrition with interventions including medication administration, tube feeding, and monitoring for weight loss. Observation on 5/2/2024 at 12:57 PM revealed she was lying in her bed sleeping. The room's floor was clean. Resident #41's bedside table had a white substance on the table which appeared to be adhered to the tabletop. The base of the bedside table was covered by a rust-colored substance. Resident #41 was observed to be receiving nutrition via a feeding tube. The base of the apparatus holding her feeding tube, electronic monitor for the feeding tube, and bags of hydration and nutrition had a rust-colored substance on all four wheelbases. Interview on 5/2/2024 at 1:32 PM with the DON, she said the facility should clean the poles for the resident's feeding tubes as needed, and at least once monthly. The DON said the poles had been cleaned the week previously. The DON said if a pole was not cleaned it could introduce bacteria or dirt into a resident's feeding tube site causing illness. The DON said she was unsure if there was a policy related to ensuring the poles were cleaned. The DON said the Admin was responsible for facility structure and environment concerns. Interview on 5/2/2024 at 2:26 PM with the Admin, she said staff had been provided with training to ensure the rooms were as homelike as possible, and the walls, bedside table, and feeding tube apparatuses in Resident #27 and #41's rooms were not homelike. The Admin said she expected all staff to look for those concerns. The Admin said executive staff also completed angel rounds looking for homelike environment concerns. The Admin said she believed the angels should have seen the concerns in Resident #27 and Resident #41's rooms. The Admin said a concern with the staff not seeing those issues was the residents would not have a homelike environment, and the facility was the home of all its residents. The Admin said the facility did not have a policy related to maintaining a homelike facility, but the angel rounds checklist should provide the information needed to ensure all residents' rooms were homelike. Record review of the facility's Guardian Angel Weekly Round Checklist revealed a statement which read Issues are addressed immediately when possible, by the Guardian Angel. Unresolved issues are documented on a Concern/Resolution form and submitted immediately to the Administrator. The checklist included areas of concern including the following: odors in the rooms, clean floors, clean bathroom, and the supplement pole clean and dated.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572 Based on interview and record review, the facility failed to refer all residents with newly evident or possible serious mental disorders, intellectual disabilities, or a related conditions for level II resident review upon a significant change in status assessment for two of eighteen residents (Resident #1 and Resident #72) reviewed for PASARR evaluations. -The facility failed to refer Resident #1 to the appropriate, State-designated authority when she was diagnosed with MDD, intermittent explosive disorder, and psychotic disorder with delusions. -The facility failed to refer Resident #72 to the appropriate, State-designated authority when she was diagnosed with major depression and schizoaffective disorder. This failure could place residents at risk for not receiving necessary PASARR mental health services, causing a possible decline in mental health. Findings include: Resident #1 Record review of Resident #1's face sheet dated 5/3/2024 revealed a [AGE] year-old woman admitted on [DATE]. The face sheet documented her diagnoses included dementia (group of symptoms that affects memory, thinking and interferes with daily life), intermittent explosive disorder (behavioral disorder characterized by explosive outbursts of anger and violence in which one reacts out of proportion to the situation), need for assistance with personal care, disorientation (altered mental state with loss of sense of time, identity, direction, and place), cognitive communication deficit (difficulty with any aspect of communication that is affected by a disruption of cognition), malnutrition (condition that results from lack of sufficient nutrients in the body), MDD (major Depressive Disorder, mental health disorder having episodes of psychological depression), GERD (Gastroesophageal Reflux Disease, chronic digestive disease where the liquid content of the stomach refluxes into the esophagus, the tube connecting the mouth and stomach), and psychotic disorder with delusions (fixed, false conviction in something that is not real or shared by other people). Record review of Resident #1's quarterly MDS dated [DATE] with an ARD of 2/27/2024 revealed a BIMS score of 11 indicating moderate cognitive impairment. The MDS documented she had no impairment of either her upper or lower extremities, and she used a wheelchair for mobility. Per the MDS, Resident #1 required assistance, or was totally dependent on staff, for all ADL's. The MDS revealed she received OT, PT, and ST services, but she had not received any psychological therapy. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's care plan dated 12/21/2022 revealed a focus on her behavioral concerns with interventions including attempting non-pharmacological interventions, ensuring physical needs were met, medication administration, and redirection. The care plan documented a focus on her making false allegations with interventions including minimizing her anxiety, orienting her to place and situation as needed, and always having two staff administer her medications. The care plan included a focus on Resident #1's depression and antidepressant medication use with interventions including conducting a GDR for an antianxiety medication, medication administration as ordered, and attempting non-pharmacological interventions. The care plan revealed a focus on diagnosis of psychotic disorder with interventions including medication administration, quarterly GDR attempts, maintaining as calm an environment as possible, and staff not arguing with her. The care plan included a focus on her dementia with interventions including providing a consistent routine and providing time to remember past details. Record review of Resident #1's PASRR dated 10/24/2022 revealed the form was negative for all MI, ID, or DD. Interview on 4/30/2024 at 10:25 AM with Resident #1, she said the staff helped her with any tasks she requested. Resident #1 said the staff assisted her with her ADL's. Resident #1 said she had no concerns with the care provided by the staff. Resident #72 Record review of Resident #72's undated face sheet revealed she was an [AGE] year-old female admitted on [DATE], with an original admission of 8/31/23. She had diagnoses of Alzheimer's Disease (progressive disease involving memory loss), Schizoaffective disorder (combination of delusions, hallucinations, depression, and manic periods), major depressive disorder, and Dementia (impaired ability to remember, think, or make decisions). Record review of Resident #72's Admission MDS assessment dated [DATE] revealed she did not have a serious mental illness. She had a BIMS score of 9 out of 15, which indicated moderate cognitive impairment. The MDS reflected diagnoses of depression and schizophrenia (delusions, hallucinations, and disorganized thinking), and the resident was taking antipsychotics and antidepressants. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #72's undated care plan revealed a Focus: Resident is having mood and behavior needs as evidence by periods of social isolation verbally aggression/agitation and delusions, related to: Dementia (impaired ability to remember, think, or make decisions), Schizoaffective disorder (combination of delusions, hallucinations, depression, and manic periods) and Major Depression (Start: 3/1/24). Goal: Resident will have a reduction in unwanted mood or behaviors, for an increased quality of life as evidenced by documentation in the medical record; Behavior Monitoring Flow record and other documentation over the next 90 days (Target: 6/1/24, Edited: 3/1/24). Interventions: Attempt non-pharmacological interventions and document interventions on the Behavior Monitoring Flow Record. Ensure physical needs are met. Give medications as ordered. Focus: Resident has dx of schizophrenia (delusions, hallucinations, and disorganized thinking) (Start: 9/1/23). Goal: Resident will interact appropriately with staff, other residents, and family members (Target: 2/14/24, Edited: 11/14/23). Interventions: Assess effect of hallucinations on resident's status. Encourage resident to discuss feelings. Provide safe, quiet, low-stimuli environment. Focus: Resident has symptoms related to schizophrenia (delusions, hallucinations, and disorganized thinking). Risperidone (antipsychotic used for schizophrenia) as ordered (Start: 9/1/23, Edited: 11/14/23). Goal: Resident will interact and converse appropriately with staff, other residents, and visitors (Target: 2/14/24, Edited: 11/14/23). Interventions: Administer medications. Focus: I have a diagnosis of depression. Venlafaxine (antidepressant), Trazodone (antidepressant) as ordered (Start: 9/1/23, Edited: 11/14/23). Goal: Will not exhibit signs of isolation thru next review date (Target: 2/14/24, Edited: 11/14/23). Interventions: Assess mood/behavior problems as needed. Record review of Resident #72's previous Nursing Home records from 6/5/23, revealed she had a history of schizoaffective disorder (combination of delusions, hallucinations, depression, and manic periods) with depression for which she was taking Seroquel (antipsychotic used to treat schizophrenia) and Effexor (antidepressant). Record review of Resident #72's PASRR Level 1 Screening performed on 9/1/23, revealed No was marked to the question, Is there evidence or an indicator this is an individual that has a Mental Illness? There was not another PASRR completed to re-evaluate her mental illness. Record review of Resident #72's Physician's Orders revealed the following orders from DO A: -Trazodone 50mg, 1/2 PO QHS. Ordered on 8/31/23 at 10:07pm, for major depressive disorder. -Venlafaxine ER 75mg, 1 PO QD. Ordered on 10/23/23 at 12:52pm, for major depressive disorder. -Risperidone 1mg, 1 PO QD. Ordered on 10/23/23 at 12:51pm, for schizoaffective disorder. Record review of Resident #72's Diagnostic Assessment from 2/21/24 at 1:50pm by LCSW A revealed she was diagnosed with a major depressive disorder and a schizoaffective disorder. Record review of Resident #72's Psychiatric Initial Assessment on 3/12/24 by NP A, revealed she was diagnosed with a schizoaffective disorder and was being treated with Risperidone (antipsychotic for schizophrenia), Trazodone (antidepressant), and Venlafaxine (antidepressant). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/1/2024 at 1:11 PM with the MDS Nurse, he said he had been employed since January of 2023. The MDS Nurse said his duties included completing and reviewing the PASRR process, importing the PASRR documents, and uploading them to the facility's EHR. The MDS Nurse said Resident #1's PASRR was completed by family prior to her arrival to the facility and a follow-up PASRR should have been completed based on her diagnoses. The MDS nurse said following a new PASRR Form 1012 should have been completed to indicate she was not eligible for PASRR services due to a primary diagnosis of dementia. The MDS nurse said the Form 1012 documented a resident was not eligible for PASRR services due to a primary diagnosis of dementia or Alzheimer's Disease. The MDS nurse said the purpose of the PASRR was to ensure residents with MI, ID, or DD who were eligible received additional PASRR services, including physical equipment, psychiatric care, and/or outside activities. The MDS Nurse said because Resident #1 was not eligible due to her primary diagnosis of dementia, he was unsure what could have occurred with her inaccurate PASRR documents. Interview on 5/2/2024 at 1:32 PM with the DON, she said the PASRR was required of all residents to determine if they were eligible for additional services based on diagnoses. The DON said Resident #1's PASRR should have been noted as positive due to her diagnoses. The DON said the facility completed an audit of all PASRR documentation on that date to ensure no other residents had inaccurate PASRR documentation. The DON said without accurate PASRR documentation, or a Form 1012, Resident #1 may not have received additional services she was eligible for. The DON said the facility did not have a policy related to PASRR, and it followed the RAI policies from CMS. Interview on 5/2/2024 at 2:26 PM with the Admin, she said if a resident's PASRR was inaccurate, he/she may not receive the services he/she was entitled to. The Admin said the PASRR allowed residents to receive outside services for MI, ID, or DD. The Admin said the facility did not have a policy specific to PASRR, but instead it relied on the RAI instructions provided by CMS.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572 Based on observation, interview and record review, the facility failed to ensure comprehensive care plans were reviewed and revised by the Interdisciplinary Team after each assessment for 4 (Resident #29, Resident #40, Resident #57, and Resident #41) out of 9 residents reviewed for care plan accuracy. -The facility failed to ensure Resident #29's most recent fall was care planned. -The facility failed to ensure Resident #40's hospice was care planned, along with her UTI/antibiotic. -The facility failed to ensure Resident #57's diet was updated on her care plan. -The facility failed to ensure Resident #41's PEG tube feeding was updated on her care plan. These failures could place residents at risk for their medical, physical, and psychosocial needs not being met. Findings include: Resident #29 Record review of Resident #29's undated face sheet revealed she was a [AGE] year-old female admitted on [DATE], with an original admitted [DATE]. She had diagnoses of dementia (impaired ability to remember, think, or make decisions), anxiety, vascular dementia (changes to memory, thinking, and behavior due to blood vessels in brain), pannus of right eye (growth of blood vessels onto the clear surface of the eye), tuberculosis of right eye (bacteria that causes Tuberculosis infects the eye), unsteadiness on feet, abnormalities of gait and mobility, cognitive communication deficit (difficulty with thinking and using language), lack of coordination, iron deficiency anemia (low iron in the blood), muscle weakness, chronic kidney disease (kidneys do not filter anymore), and disorientation. Record review of Resident #29's Quarterly MDS assessment dated [DATE], revealed a BIMS score of 11 out of 15 which indicated moderately impaired cognition. The resident had impairment on one side of her lower extremities and used a wheelchair. She required substantial/max assistance with showers/baths and was dependent with putting on/taking off footwear. She needed partial/moderate assistance with oral hygiene, toileting hygiene, upper/lower body dressing, and personal hygiene. She was always incontinent of bowel and bladder. The MDS revealed there were no falls yet at the time of the assessment. Record review of Resident #29's undated care plan, revealed a Focus: Resident had a fall on 12/15/23 attempting to get herself out of bed (Start: 12/15/23, Edited: 2/9/24). Goal: Resident will remain free from injury with increased supervision thru next review date (Target: 5/9/24, Edited: 2/9/24). Interventions: Keep call light in reach at all times. Provide toileting assistance frequently. It did not have the most recent fall from 3/14/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #29's progress notes revealed a note from LVN A on 3/14/24 at 9:45pm, Resident was found alongside of her bed in a high fowlers position [head of the bed raised to 60-90 degrees], Resident showed no s/s of discomfort, no injuries, vitals stable, NP and DON notified along with her relative [family member] Monitor in place. Interview and observation with Resident #29 on 5/1/24 at 1:26pm using interpreter services, she revealed she could only understand some of the staff since she spoke a language other than English. The resident was sitting in her wheelchair and rocking back and forth. Resident #40 Record review of Resident #40's undated face sheet, revealed she was a [AGE] year-old female admitted [DATE] with an original admitted [DATE]. She had diagnoses of Type 2 diabetes (body does not produce insulin or is resistant to it), urinary tract infection, muscle wasting and atrophy, protein calorie malnutrition (body is not receiving enough nutrition), elevated white blood cell count (usually means an infection), chronic myeloproliferative disease (bone marrow makes too many red blood cells, white blood cells or platelets), history of venous thrombosis and embolism (blood clot in a vein and a clot that travels through the vein to another location), stress fracture (fracture from too much pressure), dementia (impaired ability to remember, think, or make decisions), disorientation, cognitive communication deficit (difficulty with thinking and using language), vascular dementia (changes to memory, thinking, and behavior due to blood vessels in brain), major depression, and need for assistance with personal care. Record review of Resident #40's Significant Change MDS assessment dated [DATE], revealed a BIMS (used to evaluate cognition) was unable to be performed due to her medical condition. According to the staff assessment for mental status, the resident had severely impaired cognitive skills. The resident required substantial/max assist with oral hygiene, toileting hygiene, upper/lower body dressing, personal hygiene, and was dependent with showers/baths. The MDS revealed the resident had a life expectancy of less than 6 months. The MDS also revealed the resident was receiving hospice care. Record review of Resident #40's undated care plan, revealed a Focus: Advanced Care Planning: Resident code status is Do Not Resuscitate, no other advanced directive (Start: 11/30/22, Edited: 3/20/24). Goal: Resident will be informed of his/her right to complete advanced directives to direct his medical care and make his values and treatment goals known. Residents stated desires will be honored (Target: 6/20/24, Edited: 3/20/24). Interventions: Advanced directives of resident's choice completed and placed on medical record under advanced directive tab or in documents. No mention of resident's Hospice. Focus: Resident is at risk for UTI's related to overactive bladder (Start: 11/30/22, Edited: 3/20/22). Goal: Resident will be free of s/s of UTI for the next 90 days (Target: 6/20/24, Edited: 3/20/24). Interventions: Administer medications as ordered. No mention of the current UTI or antibiotic she was on, was mentioned on the care plan. Record review of Resident #40's Physician's Orders revealed the following orders from DO A: -Admit to [name of hospice] with DX: senile degeneration of the brain (symptom of Dementia where the brain shrinks), chronic myeloproliferative disease (bone marrow makes too many red blood cells, white blood cells or platelets). Ordered on 3/22/24 at 5:51am. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Admit to [name of hospice, name of doctor, phone number], Call to report any change in condition. Ordered on 4/15/24 at 12:28pm. -Nitrofurantoin monohyd/m-cryst (type of antibiotic) 100mg capsule, 1 PO QD for UTI. Ordered on 4/26/24 at 11:35am. Record review of Resident #40's progress notes revealed a note from LVN B on 4/27/24 at 3:05am, N/O day 1/10 Nitrofurantn Mono [type of antibiotic] 100mg cap po once daily x 10 days, initial dosed given at 2300. All meds tolerated well . Resident #57 Record review of Resident #57's undated face sheet revealed she was a [AGE] year-old female admitted [DATE], with an original admitted [DATE]. She had diagnoses of dementia (impaired ability to remember, think, or make decisions), major depression, Alzheimer's disease (progressive disease involving memory loss), muscle wasting and atrophy, neurofibromatosis (three genetic diseases caused by mutations in genes that lead to increased risk of developing tumors), dysphagia (trouble swallowing), type 2 diabetes (body does not produce enough insulin or resists it), lack of coordination, and cognitive communication deficit (difficulty with thinking and using language). Record review of Resident #57's Annual MDS assessment dated [DATE] revealed a BIMS (used to indicate cognition) was unable to be completed due to the resident's condition. The Staff Assessment for Mental Status revealed the resident had severely impaired cognitive skills. The MDS revealed the resident was substantial/max assist with eating, oral hygiene, toileting hygiene, upper/lower body dressing, personal hygiene, and dependent with shower/baths, and putting on/taking off footwear. According to the assessment the resident had a loss of 5% or more in the last month or a loss of 10% or more in the last 6 months and was not on a physician prescribed weight loss regimen. She was on a mechanically altered diet (requires a change in texture of food or liquids) while a resident. Record review of Resident #57's undated care plan, revealed a Focus: RD Nutritional Monitoring Note: Wt loss x 180 days 13#, 10%, #/9% x 90 days, Current wt: 124#/BMI: 22.84, despite consuming 51-75-100% meals. (Start: 2/2/23, Edited: 2/5/24). Goal: I will be able to demonstrate proper methods of swallowing without s/s of aspiration (Target: 3/25/24, Edited: 12/26/23). Interventions: Obtain dietary consult: RD rec add 1 ice cream QHS. Focus: Citizen is receiving a Therapeutic Diet of Heart Healthy (Start: 2/2/23, Edited: 12/26/23). Goal: Citizen will have adequate nutrition and fluid intake thru the next review date (Target: 3/25/24, Edited: 12/26/23). Interventions: Offer snacks within diet. Serve diet as ordered per MD. The care plan did not have the updated diet of pureed with large portions, and the 2 Kcal HN. Record review of Resident #57's progress notes revealed a note from LVN C on 3/5/24 at 6:15pm, Resident noted choking on dinner during feeding, diet recently was downgraded to easy to chew further downgrade to puree placed, following ST consult RP, MD notified (continued on next page)

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	676362	A. Building B. Wing	05/03/2024

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #57's progress notes revealed a note from the Dietary Manager on 4/3/24 at 3:44pm, RD Nutritional Monitoring Note: Incurred 6#/5% x 30 days, 9#/7.8% x 90 days wt: 116#/BMI 21.27. Diet: House Pureed Lg portions, health shake all meals, Ice cream cup q HS, 2 Kcal HN [type of nutritional supplement] at 180cc's QID. Intake 51-100% meals consumed, despite receiving mirtazapine [medication to increase appetite] .RD rec increase 2 Kcal HN [type of nutritional supplement] to 200cc's QID, weekly wts x 4 weeks, super pudding q HS. Record review of Resident #57's Medical Nutrition Therapy Recommendation from the Dietary Manager on 4/3/24, revealed .RD rec increase 2 Kcal HN [type of nutritional supplement] to 200cc's QID, weekly wts x 4 weeks, super pudding q HS. The physician checked he agreed and signed off on it on 4/4/24. Record review of Resident #57's Physician's Orders revealed the following orders from DO A: -Add Lg portions at bkf meals. Ordered on 4/4/23 at 1:05pm. -House Pureed. Large breakfast portions 1 health shake all meals 1 ice cream q HS. Ordered 4/19/24 at 1:31pm. Resident #41 Record review of Resident #41's undated face sheet revealed she was an [AGE] year-old female admitted on [DATE], with an original admitted [DATE]. She had diagnoses of osteomyelitis (infection of bone) of right ankle and foot, bacterial infection, gastrostomy (opening into stomach that for nutrition), disorientation, dysphagia (trouble swallowing), cognitive communication deficit (difficulty with thinking and using language), pneumonia (infection in the lungs), muscle wasting and atrophy, depression, and lack of coordination. Record review of Resident #41's Quarterly MDS assessment dated [DATE], revealed a BIMS (used to evaluate cognition) score could not be provided due to her condition. Staff Assessment for Mental Status indicated she had severely impaired cognitive skills. The MDS revealed a diagnosis of gastrostomy (opening into stomach that for nutrition) and dysphagia (trouble swallowing). According to the MDS assessment the resident was receiving nutrition through a feeding tube while a resident. She was receiving 51% or more total calories through the tube feeding and 501cc/day or more through the tube feeding. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #41's undated care plan, revealed a Focus: Resident Wt gain 7#/6.3% x 30 days, 23#/11% x 90 days (Start: 5/2/23, Edited: 3/14/24). Goal: Prevent aspiration (inhaling food or water), choking, dehydration, N/V and dehydration, and excess residuals, wt gain maintain wt +/- 5# x 90 days (Target: 6/14/24, Edited: 3/14/24). Interventions: RD rec decrease rate TF: Jevity 1.5 at 55cc's qhr x 22 hrs, increase water flush 175cc's a 6 hrs .Focus: I am at risk for malnutrition and/or dehydration related to dysphagia. Renal Diet, minced/moist as ordered (Start: 2/1/23, Edited: 3/14/24). Goal: Will maintain nutritional status as evidenced by no significant wight changes through next review. Will receive appropriate diet as ordered by physician (Target: 6/14/24, Edited: 3/14/24). Interventions: Diet as ordered by physician. Encourage intakes of foods and fluids, offer alternatives if intakes do not appear adequate. Focus: I am at risk for malnutrition and dehydration related to enteral feedings secondary to dysphagia (trouble swallowing). Nepro 1 or 2 cans via bolus if less than 50% meal consumed as ordered (Start: 11/4/22, Edited: 3/14/24). Goal: Maintain weight with no significant changes through next review. Will tolerate tube feeding (tube into stomach for nutrition) as ordered as evidenced by no nausea, vomiting, diarrhea, placement checks, residual checks (how much is left in stomach between feedings), and weight stability (Target: 6/14/24, Edited: 3/14/24). Interventions: Provide tube feeding (nutrition via a tube into stomach) and water flush as ordered Record review of Resident #41's Physician's Orders revealed the following orders by DO A: -NPO continuous. Ordered on 12/8/22 at 9:36pm. -Enteral Feeding (feeding into stomach via tube): Formula Jevity 1.5, Strength Flow Rate Jevity 1.5 at 45 cc's q hr x 22 hrs, Every shift. May use Fibersource if Jevity unavailable. Ordered on 12/5/23 at 11:09am. -Enteral Feeding (feeding into stomach via tube): Flush tube with 250cc's water Q 6 hrs, Every 6 hours at 6am, 12pm, 6pm, and midnight. Ordered on 12/5/23 at 11:09am. -Bowel Rest, Once a day from 8am-10am. Ordered on 1/17/24. In an observation of Resident #41 on 5/1/24 at 10:03am, she had Jevity 1.5 running at 45ml/hr with water flush 250ml Q6hr. Interview with the MDS Nurse on 5/3/24 at 10:00am, he said he had been an MDS Nurse since February 2019 but had been at the facility since January 2023. He said he found out about updates in the morning meetings when they discussed changes in residents and then he would update the care plans at that time. He said he updated all aspects of the care plans. He said sometimes the care plans were updated by the nurses, but he usually told them to come to him with all the care plan issues and he would take care of it because he was always there and that was all he did. He said he knew he had 48hrs for a baseline care plan and 14 days for the comprehensive care plan, but he got the care plans updated within a couple hours and did not wait because the care plans would get backed up and it was hard to get caught up again. He said Resident #29's fall should have been on the care plan, Resident #40's hospice and UTI/antibiotic should have been on the care plan, Resident #57's diet should have been updated, and Resident #41's diet/PEG rate should have been updated. He said he missed it out of human error, and he was going to fix it right then. He said care plans were specific modalities of care and specific ways to care for residents. He said if the care plan was wrong or not updated then the resident could get care that was not needed or wrong. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policies and procedures on Person-Centered Care Plan (revised: 10/1/20) read in part: .Comprehensive Care Plan: Developed after completion of the discipline-specific assessment and within one (1) week after completion of the MDS. Will be reviewed and updated as needs are identified and after each MDS assessment .The person-centered care plan is interdisciplinary and created to guide facility staff in providing the treatment, care and services necessary for the patient/resident to obtain and maintain the highest physical, mental, and psychosocial well-being possible. The plan is also used to promote patient/resident and family involvement in planning care .The MDS department schedules assessment dates and the Social Services department schedules the care plan conference to coordinated follow the assessment reference date (ARD) .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47572 Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 (Resident #64) of 9 residents viewed for infection control. -LVN D did not wear appropriate PPE when administering Resident #64's PEG (tube into stomach for nutrition) tube medications, when he was on Enhanced Barrier Precautions. This failure could place residents and staff at risk for cross-contamination, spread of infection and could potentially affect all others in the building. Findings include: Record review of Resident #64's undated face sheet revealed she was a [AGE] year-old female admitted on [DATE] with diagnoses of multiple sclerosis (immune system attacks covering of nerve cells in brain, optic nerve, and spinal cord), contusion (bruise) of right great toe, muscle wasting and atrophy, need for assistance with personal care, gastrostomy (surgical opening to the outside from the stomach), dysphagia (trouble swallowing), cognitive communication deficit (difficulty with thinking and using language), functional quadriplegia (immobility from medical condition without injury), and conversion disorder with seizures (condition where a mental health issue disrupts how brain works). Record review of Resident #64's Admission MDS assessment dated [DATE] revealed a BIMS (used to evaluate cognition) could not be assessed due to her condition. Staff Assessment for Mental Status revealed she had severely impaired cognitive skills. She had impairment on both sides of her upper and lower extremities and was bed bound. According to the assessment she was dependent with all ADLs. The MDS revealed diagnoses of gastrostomy (surgical opening from stomach to the outside) and dysphagia (trouble swallowing). The MDS assessment revealed she had a swallowing disorder and received nutrition through a feeding tube while a resident. She received 51% or more of her total calories through the tube feeding (tube into stomach for nutrition) and 501 cc/day or more of her fluid intake through the tube feeding. At the time of the assessment, she did not have any pressure ulcers/injuries. Record review of Resident #64's undated care plan revealed a Focus: I am at risk for malnutrition and dehydration related to enteral feedings (tube into stomach for nutrition) secondary to MS (Start: 1/18/24, Edited: 4/25/24). Goal: Maintain weight with no significant changes through next review. Will tolerate tube feeding (tube into stomach for nutrition) as ordered as evidenced by no nausea, vomiting, diarrhea, placement checks, residual checks (how much feeding is left in stomach after last feeding), and weight stability (Target: 7/25/24, Edited: 4/25/24). Interventions: Provide tube feeding (tube into stomach for nutrition) and water flush as ordered. Record review of Resident #64's Physician's Orders revealed the following orders from DO A: -Cephalexin (antibiotic) 500mg capsule, 1 via G-Tube (tube into stomach for nutrition) BID, for contusion (bruise) of right great toe with damage to nail. Ordered on 4/25/24 a 2:08pm. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview with LVN D on 5/1/24 at 1:20pm, Resident #64 had an Enhanced Barrier Precaution sign on her door to her room. LVN D went into the resident's room and gave her medication through her PEG (tube into stomach for nutrition) tube with only gloves on and did not put a gown on. LVN D said Resident #64 was on Enhanced Barrier Precautions which required her to don (put on) gloves and a gown during medication administration. LVN D said she forgot to put the required PPE on and said if she did not wear it, contamination to herself or to the resident could occur. Interview with the DON on 5/3/24 at 10:34am, she said the Enhanced Barrier Precaution sign on the resident's door was for whichever resident had a line (PEG [tube into stomach for nutrition], foley [tube into bladder], PICC [type of line to give antibiotics through], trach [hole in trachea to breathe through], etc.) or a wound. She said she expected staff to gown up anytime they performed resident care, like giving medications through a PEG (tube into stomach for nutrition) tube. She said there were no orders for the Enhanced Barrier Precautions in the system because it was a standing protocol depending on the status of each resident. She said if staff did not wear appropriate PPE cross contamination could occur to themselves or the resident. Record review of the facility's policies and procedures on Transmission Based/Standard Precautions, and Enhanced Barrier Precautions (revised 5/15/23) read in part: The facility will use transmission-based precautions when the route of transmission is not completely interrupted using standard precautions alone. These are applied as needed based on the epidemiology of the infecting organism or infectious disease syndrome. There may be some diseases that have multiple routes of transmission which more than one transmission-based precaution may be required. Transmission based precautions will always be used in addition to standard precautions. Health care workers (HCW) will implement Universal/Standard Precautions whenever there is occupational exposure to blood and body fluids .Health care workers will implement enhanced barrier precautions according to policy with additional measures to protect residents and staff from Multidrug-resistant Organisms (MDROs) .Enhanced Barrier Precautions expand the use of PPE (gowns and gloves) during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP will be implemented for All residents with the following: Infection or colonization with an MDRO when Contact Precautions do not otherwise apply. Wounds and/or indwelling medical devices (central lines, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. EBP will be implemented during the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toilet, device care or use: central lines, urinary catheter, feeding tube, tracheostomy/ventilator .EBP requires the following PPE: gloves, gown .The facility will post clear signage on the door or wall outside of the room indicating the type of precautions and required PPE (gowns and gloves). The facility will post signage that clearly indicates the high-contact resident care activities that require the use of gown and gloves .