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	06/26/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to prevent complications for 1 (Resident #58) of 2 resident reviewed for gastrostomy tubes (a surgically implanted tube into the stomach to provide delivery of nutrition). CNA-A paused the tube feeding pump, instead of informing the nurse immediately to turn off the pump for Resident #58, prior to lowering the head of bed (HOB). This failure could place residents with g-tubes at risk of complications such as aspiration, incorrect settings on the pump and delay in receiving feedings as physician ordered. Findings include: Record review of Resident #58's face sheet dated 06/25/25 revealed a [AGE] year-old first admitted to the facility on [DATE]. Diagnoses included multiple sclerosis (a chronic neurological disorder), muscle wasting, Dysphagia (swallowing disorder), Parkinsonism (a nervous system disorder), conversion disorder with seizures or convulsions (a mental health condition that causes physiological symptoms), anxiety, functional quadriplegia (inability to completely move) and gastrostomy status (a surgically implanted tube to allow provision of nutritional support). Record review of Resident #58's quarterly MDS dated [DATE] revealed she had short term and long-term memory problems. She had severely impaired cognitive skills for daily decision making. She had continuous behaviors of alerted level of consciousness. She required total assistance from staff for all ADLs. She required a feeding tube for nutritional support. Record review of Resident #58's June 2025 MARTAR revealed on 6/25/25, every shift, the HOB was elevated 30 - 45 degrees during enteral feeding. On 6/25/25 she received enteral feeding: Formula Jevity 1.5 at 42ml/hr for 22 hours via pump every shift. Record review of Resident #58's undated care plan revealed Problem - category Feeding Tube: Resident #58 receives Jevity 1.5 via g-tube at 50ml/hr x 22 hours, edited on 04/22/25. Goal - Resident #58 will remain free of complications related to G-tube, including aspiration/infection. Approach included: elevate HOB 30 - 45 degrees during feeding and one hour after. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 06/25/25 at 12:40 PM, Resident #58 was leaning over to her left side, head unsupported. The HOB was raised at least 45 degrees and TF pump was infusing Jevity 1.5 formula at 42 cc/hr into resident's g-tube. CNA-A stated 2 hours ago she had changed Resident #58's brief and she was not leaning over in that position. CNA-A repositioned Resident #58 by centering her in the bed, then pressed the pause button on the tube feeding pump. CNA-A did not call for a nurse to assist with the tube feeding pump. CNA- A then lowered the HOB and took the wedge from the chair and positioned it underneath the left side of Resident #58's back. CNA-A raised the HOB and then turned the tube feeding pump back on. CNA-A stated she would get a pillow for Resident #58's head. When she was done with Resident #58, she walked out of the room and walked halfway down the hall to retrieve the meal cart. CNA-A did not notify the nurse about Resident #58. CNA-A stated she would notify the nurse about finding Resident #58 leaning over to one side. CNA-A stated it was her understanding that aides were allowed to pause the tube feeding pump when HOB is lowered to provide ADL care. CNA-A stated only the nurses were allowed to touch/pause the pump. CNA-A stated she paused the pump because sometimes the nurses were busy and could not come to pause the pump for her to complete ADL care tasks. In an interview on 6/25/25 at 12:55PM, LVN-B stated Resident #58 gets bowel rest between 8:00AM and 10:00AM, then she restarted the tube feeding. She stated Resident #58 was sitting upright at almost 90 degrees when she left her. LVN-B stated Resident #58 does move around and can end up leaning to either right or left side. LVN-B stated that only the nurses were allowed to pause the feeding pump and expected the CNAs to call her if they need the pump to be paused. LVN-B stated she believed it was the Board of Nursing policy that only nurses were allowed to touch the pump. LVN-B stated the CNAs were not trained to monitor a resident on tube feeding and they cannot assess residents. LVN-B stated the risks would be aspiration and if she had turned the pump off, she would also check the tubing for kinks. In an interview on 06/25/25 at 2:35PM, the DON stated she expected the CNAs to get the nurse for assistance when pausing the tube feeding pump is needed. The DON then stated she encourages the nursing staff to call for nurse assistance. The DON stated there were multiple risks if a CNA were to pause the pump without nurse assistance. The DON stated the CNAs do not know how to read the pump, settings could get readjusted, and a risk to the resident could be aspiration. The DON stated an in-service and demonstrations were conducted last month (May 2025) for all nursing staff which included do not touch the pump, for the CNAs. Record review of the facility's policy and procedures for Gastrostomy Tubes, revised May 5, 2023, and received on 6/25/25 at 2:45PM, included a G-tube/Nurse, CNA responsibility signature sheet dated 05/31/25. CNA-A signed the sheet. The policy read in part: .2. The patient/resident that is fed by enteral methods receive the appropriate treatment and services to restore oral eating skills and prevent complications of enteral feeding, like aspiration pneumonia . Record review of page 1 of the facility's G-tube policy and procedure, nurses and CNA in-service dated 5/31/25, conducted by the ADON, was received on 6/26/25 at 11:15PM, read: .In general and in emergency situations: CNA do not touch g-tube pump, do not attempt to unhook a resident. Get with nurse for all G-tube related care or while providing care * please get the nurse for assistance, rather than pausing pump** unless an emergency situation arises. Immediately notify the nurse. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Position Description: Certified Nursing Assistant, revised on 11/2016 read in part .Essential Functions and Responsibilities: .16. Maintains knowledge of equipment set-up, maintenance, and use (ie., restraints, monitors, drain devices, lifts, weight machines, etc.) .17. A. Operates all equipment in a safe manner; only uses equipment for which training has been received . Further review did not include the use of tube feeding pumps.

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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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interviews, the facility failed to dispose of garbage and refuse properly for 2 of 2 dumpsters in that: The facility failed to ensure the dumpster lids were closed on 2 of 2 dumpsters and the area surrounding the dumpsters were free of garbage and debris. These failures could affect residents who resided in the facility and the public by placing them at risk of exposure to germs, disease, and an environment which could attract pests and rodents. The findings include: In an observation on 6/24/25 at 9:35 AM of 2 of 2 dumpsters located outside the nursing facility, the lids were open on both dumpsters. The dumpsters were not full. Two disposable gloves, a mask, a bag of garbage, a tin can, and papers were on the ground next to the dumpsters. The Dietary Manager closed both dumpster lids immediately upon observation. During an interview on 6/24/25 at 9:37 AM, the Dietary Manager stated that the dumpster lids were to always remain closed to maintain pest control. She stated it had been the responsibility of all staff that use the dumpster to close the lid after placing garbage inside. During an interview on 6/25/25 at 8:50 AM, the Housekeeping Manager stated that all the department staff disposed of trash in the dumpsters. The housekeeping staff are trained to close the lid and make sure garbage is in the container and not on the ground. During an interview on 6/26/25 at 3:10 PM, the Administrator stated that dumpster lids were to always remain closed. The maintenance director does rounds outside the facility in the mornings and will pick up garbage if he sees any. She stated that in-service was conducted on 6/25/25 for dietary and nursing staff on placing garbage inside the dumpsters and securing the lids. The number of times the dumpsters are emptied during the week has been increased from 2 to 3 times per week. No policy on garbage and refuse disposal was provided by time of exit on 6/26/25 at 4:30 PM.