STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676434	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Houston Transitional Care	9814 Grant Rd Houston, TX 77070

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47722 Based on interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 (CR #1) of 5 residents reviewed for accident hazards. -The facility failed to securely strap CR #1's air mattress to the bed frame, causing the mattress with the resident to fall off the bedframe to the floor and CR #1 was sent to the hospital for evaluation. This failure could place residents at risk of falls, injuries, and hospitalization . Findings include: Record review of CR #1's undated face sheet revealed he was a [AGE] year-old male admitted to the facility on [DATE], with an original admitted [DATE]. He had diagnoses of unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), TIA (mini strokes), reduced mobility, lack of coordination, type 2 diabetes (body does not produce insulin or resists it), muscle wasting and atrophy, muscle weakness, cognitive communication deficit (does not recognize everyday social cues, both verbal and non-verbal), and seizures. Record review of CR #1's Quarterly MDS assessment dated [DATE], revealed a BIMS could not be performed due to his medical condition. His cognitive skills for daily decision making were severely impaired. The resident was dependent on all ADLs. He was also dependent with all mobility. The resident had not had any previous falls. CR #1 was on a feeding tube for nutrition due to trouble swallowing. He also had 2 Stage 3 pressure ulcers (sores through the first layer of skin where fat may be visible, but bone, tendon or muscle is not exposed) and 1 Stage 4 pressure ulcer (sore extends through all layers of skin where there is exposed bone, tendon, or muscle). CR #1 was receiving pressure ulcer/injury care and had a pressure reducing device for the bed. The resident was on an anticoagulant. Record review of CR #1's Care Plan dated 4/3/24, had a Focus: Resident is at risk for falls with or without injury related to altered mental status, history of falls (initiated: 4/3/24). Goal: Will not experience a fall related to risk factors (initiated: 4/3/24, target: 7/2/24). Will not have any major injuries related to fall (initiated: 4/3/24, target: 7/2/24). Interventions: Keep personal items frequently used within reach. Keep within supervised view as much as possible. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676434	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Houston Transitional Care	9814 Grant Rd Houston, TX 77070

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR #1's medical record revealed a Physician Progress Note from 4/17/24 at 7:12 pm by MD A that said he had not had any falls and the resident was contracted, had limited ability to turn, and would not follow commands and was nonverbal. Record review of CR #1's medical record revealed a Fall Risk Observation/Assessment from 4/19/24 at 8:00 am by LVN A, that revealed the resident was a low risk for falls. Record review of CR #1's medical record revealed a nurse's note from LVN A on 4/19/24 at 8:51am that read, This nurse heard beeping coming from resident's room and went to check Enteral Feeding Machine [nutrition going into stomach by machine]. Upon entering room this nurse noticed that Air Mattress was on the Right side of the bed, unsecured to frame and resident was on the floor wrapped in his sheets and blankets. Resident was awake and alert, lowly moaning. Resident was laying on his Right side facing the bed w/ his right arm extended awkwardly out behind him. This nurse replaced mattress back on bed .Resident did display facial and verbal signs of pain when moved .resident is contracted in BUE and BLE .Sending resident to [hospital] ER for eval/treat as indicated to R/O head trauma. Record review of CR #1's medical record revealed an SBAR from LVN A on 4/19/24 at 9:13am that read, The Change in Condition/s reported on this CIC Evaluation are/were: Falls .Blood Pressure: 114/74 Lying L arm, Pulse: 112, RR: 18, Temp: 98.6 Forehead, Weight: 122.4lb Hoyer, Pulse Oximetry: 97% Room Air . Nursing observations, evaluation, and recommendations are: it appears that resident fell out of bed d/t air mattress not being secured to bed frame. Record review of CR #1's hospital records from 4/19/24 at 5:08pm read .Pt fell at SNF and was taken to the ER today. At baseline pt is AOx1 and bedbound The hospital records did not indicate there were any injuries from the fall. Interview with the family on 4/20/24 at 2:45pm, she said CR #1 was sent to the hospital after falling out of bed. She said the hospital staff asked her how CR #1 fell out of bed since he was contracted and could not move. She was unsure how the fall happened, but knew the staff had to turn him because he could not turn himself. Interview with LVN A on 7/2/24 at 12:05pm, he said he was the nurse who found CR #1 on the floor on 4/19/24. He said he heard beeping coming from the room and knew it was the PEG tube beeping. He said he found the resident wrapped up in sheets on the floor and the air mattress standing up on the side of the bed. He said Maintenance was responsible for putting the air mattresses on the beds and securing them. He said if he was in the room when Maintenance was applying one, he would double check to make sure it was secured, but typically he assumed it was if it was already there. He said when he found CR #1 on the floor, the mattress was not secured to the bed like it was supposed to be and he felt bad for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676434	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Houston Transitional Care	9814 Grant Rd Houston, TX 77070

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON on 7/2/24 at 12:19pm, she said Maintenance puts the air mattresses on the beds and ensured they were strapped on and secured. She said the nurses only ensured they were plugged in and aired up. The DON said after CR #1 fell and they realized the air mattress was not secured to the bed, they performed a facility wide air mattress sweep and no other air mattresses were found unsecured. The DON also said she performed in-service training on abuse, neglect, fall reporting, and resident monitoring with all the staff after the incident. She said leadership added inspection of air mattresses to their Ambassador Rounds, which happened every morning. The DON said Ambassador Rounds were when leadership would round on the residents every morning and ensured they had their needs met and did not have any grievances. She said the Maintenance Director at the time said he secured it, but apparently it was not. She said the Maintenance Director no longer worked at the facility. She also said CR #1 did not have an order for the air mattress, but they automatically put residents on them if they had a Stage II Pressure Ulcer or higher. Interview with the ADM on 7/2/24 at 2:19pm, he said his expectations were for the air mattresses to be maintained in a working order and applied safely to the beds. He said the Maintenance Director was ultimately responsible for putting the air mattress on the bed and for checking them routinely to ensure they were attached properly. He said the air mattresses were checked during room rounds now, so everyone ensured they were secured. The ADM said if the air mattress was not secured to the bed, when the resident's weight was shifted the resident could topple over and fall on the ground. Record review of the facility's air mattress bed sweep conducted on 4/28/24 by the previous Maintenance Director, revealed there were 5 other air mattresses in the facility with a note that said, All accounted for, no holes .witnessed [in] air mattresses-secured, no broken frames. Record review of the facility's current Room Check: Mattresses performed by the current Maintenance Director, for the month of June revealed, there were 5 rooms with air mattresses that were all checked on different days in June with no problems. Record review of the facility's In-Service Training Report conducted on 4/22/24 at 1pm by the DON revealed, it was conducted on notification of all falls, accidents, and hazards, checking on all residents frequently; especially high-risk residents, wounds, air mattress, fall mats .frequently for changes. Record review of the facility's policy and procedure on Assessing Falls and Their Causes (revised March 2018) read in part: The purpose of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall .Falls are a leading cause of morbidity and mortality among the elderly in nursing homes .Falling may be related to underlying clinical or medical conditions . and/or environmental risk factors. Residents must be assessed upon admission and regularly afterward for potential risk of falls. Relevant risk factors must be addressed promptly .Complete an incident report for resident falls no later than 24 hours after the fall occurs. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred .Within 24 hours of a fall, begin to try to identify possible of likely causes of the incident .Evaluate chains of events or circumstances preceding a recent fall .Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676434	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Houston Transitional Care	9814 Grant Rd Houston, TX 77070

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy on Accidents/Hazards and/or Air Mattresses was requested on 7/2/24 but the facility did not provide one.