STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676490	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sylvan Shores Health and Wellness	3950 Underwood Rd LA Porte, TX 77571

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215 Based on observation, interviews and record reviews, the facility failed to ensure each resident was treated with respect and dignity, and care for residents in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 of 5 residents (Resident #10) reviewed for resident's rights, in that: -Resident #10 whose bedsheet was pulled over her face during incontinence care, while she was crying, was not treated with dignity or respect in her own room. This failure placed residents who are totally dependent on staff for incontinence care, at risk for having feelings of poor self-esteem, decreased self-worth, and loss of dignity. Findings: Record review of Resident #10's Face sheet revealed a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses, abnormalities of gait and mobility (abnormal walking pattern with many possible causes like an injury, sore or inner ear issue or nerve damage), muscle weakness (when full effort doesn't produce a normal muscle contraction or movement), contracture right shoulder (a condition where the synovial membrane-a soft tissue that forms a protective capsule around the shoulder joint), contracture left shoulder, contracture right elbow, contracture left elbow, contracture right wrist, contracture left wrist, cognitive communication deficit (a communication difficulty that results from a cognitive impairment, such a brain injury, and can affect both verbal and nonverbal communication) and oropharyngeal dysphagia (a swallowing difficulty that occurs during the oropharyngeal phase of swallowing. Record review on Resident #10's Admission MDS assessment dated [DATE], revealed she had a BIMS score of 12 out of 15, indicating she had moderate cognitive impairments. Further record review revealed she was dependent for toileting hygiene, shower/bath, upper body, and lower body dressing, eating, oral hygiene and personal hygiene. She did not walk and used a wheelchair for mobility. She was dependent on chair to bed transfer and was also dependent on being rolled left and right. (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: 676490	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on of Resident #10's Baseline Plan of Care dated Admission: 7/7/22, Focus, Resident #10 will remain on long-term care at this facility. Goal, [NAME] will remain comfortably as a resident in the facility through next review date. Intervention, assist resident in becoming comfortable in LTC setting; introduce me to new roommate if applicable. Focus, Resident #10 is dependent on staff for cognitive stimulation, activity attendance, and social interaction related to cognitive impairment. She has potential for altered activity pattern. When she chooses not to participate in organized activities, turn on TV or her tablet in room/hallway to provide sensory stimulation. Goal, Resident #10 will maintain involvement in cognitive stimulation, social activities as desired through review date. Intervention, all staff to converse with resident while providing care. Encourage ongoing family involvement. Invite the resident's family to attend special events, activities, meals. Interview on 8/29/2024 at 11:59 a.m., with the Administrator, said she received a phone call on Sunday 8/25/2024, from the weekend supervisor, RN A. She said RN A told her that Resident #10 alleged CNA A put a sheet over her head and his hand over mouth. She said she removed CNA A from the floor and suspended him. She said she asked RN A to do a head-to-toe assessment on Resident #10. She said she talked to CNA A over the phone, and he denied the allegations. She said CNA A said the allegations were not true. She said before she suspended him, he tried to explain himself to Resident #10's family member about what happened, while he visited her at the facility. She said RN A called CNA A back into Resident #10's room and he apologized to the family member and told him he was shaking Resident #10's sheets and the sheet went over her head. She said he told the family member that he tried to remove the sheet from over Resident #10's head and his hands brushed her mouth. She said the family member said Resident #10 signed the word, liar. She said CNA A eventually left the room and went home. She said she called the DON to come to the building and she submitted the self-report. She said the DON told her that RN A did an assessment on the resident and there were no injuries. She said by the time the DON arrived; the family member had left the facility. Interview on 8/29/2024 at 12:18 p.m., with the DON, she said she received a call from the Administrator, and she told her RN A, CNA A and the family member had left the building. She said she could not reach everyone on the phone, but she was able to talk to the family member. She said the family member explained to her what happened and how CNA A tried to explain to him what happened. She said the family member told her that Resident #10 said CNA A was lying. She said she gave abuse and neglect trainings the same day of the incident. She said she explained to Resident #10 that another nurse was assigned to her during the week, but sometimes CNA A helped on the weekends when the aide was off. She said the family member wanted Resident #10 to have 1 on 1 which was something he would have to pay for. She said 1 on 1 was something they offered in the past, but he declined the services. Observation and attempted interview on 8/29/2024 at 12:30 p.m., with Resident #10, revealed her lying in bed on her right side. She was watching a movie on a tablet. She had a sheet covering her from her chest to her feet. She had an item rolled up under fingers on each hand. The television was on, and she was lying down on a blow-up mattress. She was not able to communicate during the interview. It appeared as if she wanted to speak by opening her mouth wide, but nothing came out. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/29/2024 at 1:11 p.m., Resident #10's family member said he was the only person that can communicate with Resident #10. He said this was the fifth biggest incident that the resident had in two years. He said on Sunday, 8/25/2024, he came to visit Resident #10 with another family member. He said he did sign language with Resident #10, and she opened her mouth when he got to the right letter. He said she was born deaf and had a muscle disease. He said when he spelled the alphabet out, she told him that a nurse put a bed sheet over her mouth because she was crying. He said he spoke to CNA A, and he said he tried to fluff the sheet out. He said Resident #10 is not able to move. He said she was able to touch her chin with her hands and in her voice, she said liar three times in a row. He said this was the sixth time he made allegations to the state. He said it was unfair that Resident #10 cannot communicate with the state, and the state did not call him to come and communicate with her. He said Resident #10 was living hell every day at the facility. He said he had meetings with staff about other incidents and over time things had gotten better but now another incident had happened. Follow-up interview on 8/29/2024 at 1:46 p.m., with the Administrator, she said the way she communicated with Resident #10 was with a communication board that was at her bedside. She said CNA A will be terminated. She said there was already a complaint against him, and she did not want to take any chances. She said he was not answering his phone and was not cooperating with the investigation. Observation and attempted interview on 9/4/2024 at 12:05 p.m., with Resident #10, revealed her sitting in a wheelchair at the dining room table and a nurse aide was assisting her with drinking with a straw out of a soda can. She had a sheet covering her from her chest to her feet. Her plate had no food left on it. It looked like she had eaten her food. She had an item rolled up in each hand. Resident #10 was trying to communicate but no words was spoken. An attempted telephone interview on 9/4/2024 at 4:46 p.m., with CNA A, he answered the phone and confirmed his first and last name. When it was explained to him the reason for the call, CNA A disconnected the call. Record review of the facility's policy titled Statement of Resident Rights revised on (date unknown) read in part . Veterans/Residents do not give up any rights when entering a TSVH nursing community. The community must encourage and assist them to fully exercise their rights. Any violation of these rights is against the law. It is against the law for any nursing community associate to threaten, coerce, intimidate, or retaliate against the veteran/resident for exercising their rights. If anyone hurts or threatens to hurt a veteran/resident, neglects their care, takes their property, or violates their dignity, the veteran/resident, has the right to file a complaint with the community administrator or with the Texas Health and Human Service by calling [PHONE NUMBER]. The veteran/resident has a right: to all care necessary for them to have the highest possible level of health; To safe, decent and clean conditions; to be free from abuse and exploitation; to be treated with courtesy, consideration and respect; to be free from discrimination based on age, race, religion, sex, nationality, or disability, and to practice your own religious beliefs; to privacy, including privacy during visits and telephone calls; to complain about the community and to organize or participate in any program that presents veterans/residents' concerns to the administrator of the community; to have community information about them maintained as confidential; to retain the services of a physician of their choice, at their own expense or through a health care plan, and to have a physician explain to them, in language they understand, their complete medical condition, the recommended treatment, and the expected results of the treatment .

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NAME OF PROVIDER OR SUPPLIER Sylvan Shores Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 3950 Underwood Rd LA Porte, TX 77571	

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47215 Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation was made for 1 (Resident #15) of 5 residents reviewed for reporting of alleged violations, in that: The facility failed to report to the state agency, an incident of neglect regarding Resident #15, after she had an unwitnessed fall in her room with a possible injury to her hip that occurred on 6/21/24. The unwitnessed fall later revealed through x-ray, Resident #15 had a left femur fracture, and it was not reported to the state until 06/25/2024 which was four days after the incident occurred. This failure could place facility residents at risk of injury of unknown origin, abuse, and neglect. Findings : Record review of Resident #15's Face sheet revealed a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnoses, fracture of shaft of left femur (a fracture in the long, straight part of the thighbone, or femur, below the hip and above the knee), hypertensive heart disease (a number of complications of high blood pressure that affect the heart), major depressive disorder, hyperlipidemia (a condition in which there are high levels of fat particles in the blood), and dementia (a group of thinking and social symptoms that interferes with daily functioning). Record review on Resident #15's Admission MDS assessment dated [DATE], revealed she had a BIMS score of 7 out of 15, indicating she had severe cognitive impairments. Further record review revealed she was dependent for shower/bath, she needed substantial/maximal assistance for upper body, and lower body dressing, eating, and personal hygiene. She needed partial/moderate assistance for oral hygiene and supervision or touching assistance for eating. She did not walk and used a wheelchair for mobility. Record review of Resident #15's Baseline Plan of Care dated Admission: 6/25/2024, Focus, Resident #15 has an intertrochanteric left femoral fracture r/t a fall. Goal, Resident #15 will remain free of pain and discomfort relating the left intertrochanteric femoral fracture through next review date. Intervention, administer pain medication as per MD ordered. Monitor for side effects and effectiveness and report to MD. Monitor fracture site and report changes to MD. Record review of Resident #15's Progress note dated 6/21/24, said, Resident #15 witnessed on floor at 1 :00am, left hip appeared dislocated-informed the Doctor -awaiting response.spoke- with Resident #15's family member-informed Resident #15 sent to HCA Southeast hospital r/t fall. Also phoned director of nursing. Awake and alert upon leaving facility. Transported per EMS at 2am-report called the ER. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Sylvan Shores Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE: 3950 Underwood Rd LA Porte, TX 77571	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/4/2024 at 1:56 p.m., with Resident #15 revealed her lying in bed, covered up with a blanket. She was lying on her back. There were two fall mats on each side of the bed. Resident #15 was not able to communicate; her call light was on the floor. Interview on 9/4/2024 at 3:24 p.m., the ADON, said Resident #15 had a fall and the DON was notified at 1:06 a.m., in the morning right after the incident occurred. She said LVN A did the assessment and put in a late entry for the risk management regarding Resident #15's fall. She said LVN A reported it to the DON. She said LVN A entered the incident into the system on 2/26/2024. She said she did not know why the incident report said the incident happened on 6/19/2024 and another one said the incident occurred on 2/21/2024. She said when an incident happens with a resident at the facility, it was important to have proper documentation and report it to the state in a timely manner so the nurses do not have to figure out what happened, and they can provide the proper care to the resident. She said she should have followed up to make sure the documentation was put in on time. Interview on 9/4/2024 at 3:46 p.m., with LVN A, said the incident occurred on night shift. She said on 6/21/2024 a CNA found Resident #15 on the floor. She said the CNA came and got her. She said she completed an assessment on Resident #15 and believed her hip was broken. She said RN B did an assessment as well. She said she called Resident #15's family member to inform him she was going to send her out to the hospital. She said the family member was Resident #15's RP. She said she reported it to the DON the same night it happened. She said she did not remember why the report was entered into the system late. She said normally the report is done as soon as it happened. She said she notified the physician so that she could send Resident #15 to the hospital. She said it was important to report the incident to the state agency's office in a timely manner because you only have a certain amount time to report it to the state. She said reporting the incident late could also be a delay in care. She said Resident #15 speaks Spanish and was not able to verbalize how much pain she was in. She said she could tell that her leg was dislocated. Interview on 9/4/2024 at 4:10 p.m., the DON, said LVN A texted her the day of the incident and she called back to see how Resident #15 was doing. She said LVN A informed her that Resident #15 was sent to the hospital. She said she was told Resident #15 might have dislocated her hip. She said the fall happened on a Friday. She said on Monday she returned to the facility to check on Resident #15. She said Resident #15 had not returned from the hospital and they usually wait for conformation from the hospital to see if there was an injury and then they would decide if the case was reportable or not. She said she reported it to the Administrator. She said she and the Administrator usually receive information if an incident occurred at the facility, at the same time via text. She said they decide together if it was reportable or not. She said it was important to notify the state of a reportable incident so they could investigate and have oversight. She said moving forward they would just report it. She said they usually create a report after an x-ray reveals an injury. (continued on next page)

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	676490	A. Building B. Wing	09/04/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy titled Incidents that a NF Must Report to HHSC and the Time Frames for Reporting revised on (date unknown) read in part . Accidents/Incidents are reported both internally and externally in accordance with the Reportable Incident Protocol (see Protocol 2-B) and the most current Texas Health & Human Services Commission (HHSC). The most current Provider Letter: PL 19-17, Dated July 10, 2019, titled: Abuse, Neglect, Exploitation, Misappropriation of Resident Property and Other Incidents that a Nursing Community (NF) Must Report to the Health and Human Services Commission (HHSC) (see Protocol 2-C). Abuse, neglect, exploitation, death due to unusual circumstances, a missing resident, misappropriation, drug theft, suspicious injuries of unknown source, fire, emergency situations that pose a threat to resident health and safety. The following table describes required reporting timeframes; immediately, but not later than 24 hours after the incident occurs or is suspected .