STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455745	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberwood Nursing and Rehabilitation Center	4001 Hwy 59 North Livingston, TX 77351

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 2 of 6 (Resident #32 and #75) reviewed for pharmacy services.The facility failed to ensure all of Resident #32's medications were administered as ordered by the Physician resulting in the incorrect dose of Vitamin D administration.The facility failed to hold Resident #75's Clonidine (used to lower blood pressure) medication (for 9 administrations) when the blood pressure was outside the Physician prescribed parameters.This failure could place residents at risk of not receiving medications as ordered by their physicians and exacerbation of their medical conditions. Findings included:Record review of Resident #32's face sheet dated 01/14/26 indicated a [AGE] year-old female admitted to the facility on [DATE] with diagnosis of protein-calorie malnutrition (insufficient intake of protein and caloric-energy), primary hypertension (high blood pressure) and chronic ischemic heart disease (decreased blood flow to heart).Record review of Resident 32's quarterly MDS dated [DATE] indicated she had a BIMS 6 of 15 indicating she had severely impaired cognitive skills for daily decision making. Record review of Resident #32's undated care plan included: Focus - Resident #32 has Osteoporosis inadequate calcium intake and Interventions - encourage intake of dairy products, cereals enriched with calcium and vitamin D and to give medications as ordered.Record review of Resident #32's physician orders dated 01/14/26 included a physician order for vitamin D3(Cholecalciferol) give 2000 unit by mouth one time a day for supplement. Date started was 02/02/21.Record review of Resident #32's January 2026 MAR/TAR indicated MA H documented administration of Vitamin D 2000 units, 1 tablet on 01/13/26 in the morning at 9:20 a.m.During an observation on 01/13/26 at 9:20 a.m., MA H prepared medications for Resident #32. MA H sanitized her hands and placed the following medications into a medication cup: Multag 400 mg one tablet, Eliquis 2.5 mg one tablet, calcium 600-400 mg one tablet, vitamin D 25 mcg (1000 units) one tablet and cetirizine 10 mg one tablet. MA H administered the medications to Resident #32 and she swallowed them without incident.During an interview on 01/14/26 at 11:30 a.m., MA H said Resident #32 received vitamin D 25 mcg (1000 units) one tablet for supplementation. MA H said the order was for vitamin D 2000 units which would have been 2 tablets of the 1000 unit tablets. MA H said she gave one tablet instead of two and stated it was her mistake and just missed it. She said she checks the medication cart drawers for each medication to ensure she has everything needed. She said then she takes each medication container and dispenses the drug into cups while checking the order again before finally administering. MA H said she received in-services from the facility regarding following physician orders, medication administration and medication errors. MA H did not see there would be any severe risk to Resident #32 when Resident #32 did not receive the full dose of vitamin D and MA H said she thought she was following the orders at the time. She said it was a medication error and would report it to the DON right away and next time she will slow down and re-check what she was doing.Record review of Resident #75's face sheet indicated an [AGE] year-old female admitted on [DATE] with diagnosis of hypertension urgency (severe sudden rise in blood pressure) and essential hypertension (high blood pressure).Record review of Resident #75's quarterly MDS assessment, dated 11/17/25, indicated a BIMS score of 15 indicating Resident #75 was cognitively intact. Hypertension and hypertension urgency were included as two of Resident #75's diagnoses.Record review of Resident #75's care plan dated 07/31/2025 indicated a diagnosis of hypertension. Interventions included Give medications for hypertension and document response to medication and any side effects.Record review of Resident #75's January 2026's physician orders indicated the following:Clonidine 0.2 mg, give 1 tablet by mouth every 12 hours for hypertension. Give for SBP greater than 160.Record review of Resident #75's January 2026 MAR indicated the following:Clonidine 0.2 mg, give 1 tablet by mouth every 12 hours for hypertension. Give for SBP greater than 160On the following dates and times, Resident #75 received Clonidine 0.2 mg when the vital signs were outside the prescribed parameters:- 01/01/2026 at 8:00 p.m., the BP was 154/72 administered by MA C;- 01/02/2026 at 8:00 a.m., the BP was 149/80 administered by MA [NAME] at 8:00 p.m., the BP was 150/78 administered by MA C;- 01/03/2026 at 8:00 p.m., the BP was 148/72 administered by MA C;- 01/04/2026 at 8:00 p.m., the BP was 148/80 administered by MA C;- 01/07/2026 at 8:00 p.m., the BP was 154/76 administered by MA C;- 01/08/2026 at 8:00 p.m., the BP was 148/76 administered by MA C;- 01/09/2026 at 8:00 p.m., the BP was 154/76 administered by MA C;-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary medications (is a medication used: without adequate indication for its use) for 1 of 5 residents (Residents #6) or excessive administration doses for 1 of 6 residents (Resident #75) reviewed for unnecessary medications. * The facility did not have appropriate diagnoses for Eliquis (blood thinner) medication for Residents #6. * The facility failed to hold Resident #75's Clonidine (used to lower blood pressure) medication (for 9 administrations) when the blood pressure was outside the prescribed parameters. These failures could place residents at risk for toxic ingestion and unintended, harmful events attributed to the use of a medication without the appropriate indication or dosage. Findings included:1. Record review of a face sheet dated 01/14/26 indicated Resident #6 was an [AGE] year-old male admitted on [DATE] and readmitted on [DATE]. His diagnoses included heart valve replacement, pacemaker, and CHF. Record review of the hospital record dated 10/02/25 indicated Resident #6 received Eliquis for pacemaker. Record review of the physician orders for January 2026 indicated Resident #6 received Eliquis for CHF. During an interview on 01/14/26 at 11:28 a.m. LVN A indicated Resident #6 had a nosebleed and the blood thinning medications were placed on hold until 01/16/25. He said he did not know about the diagnosis for the Eliquis. During an interview on 01/14/2026 at 01:39 p.m. the DON said the diagnosis for the Eliquis should be the atrial fibrillation and the pacemaker since the diagnoses were on the hospital paperwork and not CHF. She said the medication would not be appropriate for CHF. Record review of Resident #75's face sheet indicated an [AGE] year-old female admitted on [DATE] with diagnosis of hypertension urgency (severe sudden rise in blood pressure) and essential hypertension (high blood pressure). Record review of Resident #75's quarterly MDS assessment, dated 11/17/25, indicated a BIMS score of 15 indicating Resident #75 was cognitively intact. Hypertension and hypertension urgency were included as two of Resident #75's diagnoses. Record review of Resident #75's care plan dated 07/31/2025 indicated a diagnosis of hypertension. Interventions included Give medications for hypertension and document response to medication and any side effects. Record review of Resident #75's January 2026's physician orders indicated the following: Clonidine 0.2 mg, give 1 tablet by mouth every 12 hours for hypertension. Give for SBP greater than 160. Record review of Resident #75's January 2026 MAR indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clonidine 0.2 mg, give 1 tablet by mouth every 12 hours for hypertension. Give for SBP greater than 160 On the following dates and times, Resident #75 received Clonidine 0.2 mg when the vital signs were outside the prescribed parameters: - 01/01/2026 at 8:00 p.m., the BP was 154/72 administered by MA C; - 01/02/2026 at 8:00 a.m., the BP was 149/80 administered by MA M and at 8:00 p.m., the BP was 150/78 administered by MA C; - 01/03/2026 at 8:00 p.m., the BP was 148/72 administered by MA C; - 01/04/2026 at 8:00 p.m., the BP was 148/80 administered by MA C; - 01/07/2026 at 8:00 p.m., the BP was 154/76 administered by MA C; - 01/08/2026 at 8:00 p.m., the BP was 148/76 administered by MA C; - 01/09/2026 at 8:00 p.m., the BP was 154/76 administered by MA C; - 01/03/2026 at 8:00 p.m., the BP was 133/77 administered by MA C; During observation and interview on 01/12/26 at 9:10 a.m. indicated Resident #75 was lying in hospital bed. Resident #75 was alert and no signs of distress were noted. Resident #75 did not mention any concerns regarding her Clonidine when she was asked if she had any issues regarding her medications. During an interview on 01/14/2026 at 2:15 p.m., MA M said on 1/02/2026 at 8:00 a.m. she administered Resident #75's Clonidine and should not have because her systolic blood pressure (top number) was not greater than 160. MA M said it was an oversight administering the B/P medications to Resident #75. MA M said she received in-services from the facility especially regarding medication administration, unnecessary medications, medication errors and that she received in-services at least monthly. MA M said a negative effect if a resident received a medication that was not accurate would be a medication error and the resident could have received a dose that was not needed. During an interview on 01/14/2026 at 2:30 p.m., the DON said her expectations were for all medications to be administered per physician orders including according to parameters. The DON said the Medication Aide or Nurse administering medications on the cart are responsible for following the physician orders written on the medication administration record. The DON said an adverse effect a resident could experience receiving a medication incorrectly would depend on the medication, but this failure could result in resident's blood pressure becoming lower. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/14/2026 at 2:40 p.m., the Administrator said his expectations were for all nursing staff to follow physician orders when administering medication to include following parameters. The administrator said an adverse effect a resident could have if not given the accurate dosage of medication was adverse side effects depending on the medication. The Administrator stated he expected medication to be administered as ordered without medication errors. During an interview on 01/14/2026 at 2:44 p.m., MA C said she should have held Resident #75's Clonidine medications as prescribed by the physician's parameter. She said if her initials were documented on the MAR, then the Clonidine was given and should not have been because the blood pressure was less than 160. MA C said it was ordered routine and to give it but that she should have read the order better. CM C said she had been educated and re-educated on administering medications with parameters at least yearly. She said she needed to slow down more and focus on reading what the order says to do. MA C said Resident #75's blood pressure could have bottomed out. A facility policy titled Administering Medications revised dated August 2022 indicated the following. 2. Medications must be administered in accordance with the written orders of the attending physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455745	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455745	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberwood Nursing and Rehabilitation Center	4001 Hwy 59 North Livingston, TX 77351

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 6 residents (Resident #75) reviewed for significant medication errors.The facility failed to ensure Clonidine (a blood pressure (BP) medication given to lower high blood pressure) was not administered 9 times in January 2026 to Resident #75 as ordered by the physician.This failure could place residents at risk of not receiving desired therapeutic outcomes, increased side effects, or a decline in health. Findings included:Record review of Resident #75's face sheet indicated an [AGE] year-old female admitted on [DATE] with diagnosis of hypertension urgency (severe sudden rise in blood pressure) and essential hypertension (high blood pressure).Record review of Resident #75's quarterly MDS assessment, dated 11/17/25, indicated a BIMS score of 15 indicating Resident #75 was cognitively intact. Hypertension and hypertension urgency were included as two of Resident #75's diagnoses.Record review of Resident #75's care plan dated 07/31/2025 indicated a diagnosis of hypertension. Interventions included Give medications for hypertension and document response to medication and any side effects.Record review of Resident #75's January 2026's physician orders indicated the following:Clonidine 0.2 mg, give 1 tablet by mouth every 12 hours for hypertension. Give for SBP greater than 160.Record review of Resident #75's January 2026 MAR indicated the following:Clonidine 0.2 mg, give 1 tablet by mouth every 12 hours for hypertension. Give for SBP greater than 160On the following dates and times, Resident #75 received Clonidine 0.2 mg when the vital signs were outside the prescribed parameters:- 01/01/2026 at 8:00 p.m., the BP was 154/72 administered by MA C;- 01/02/2026 at 8:00 a.m., the BP was 149/80 administered by MA [NAME] at 8:00 p.m., the BP was 150/78 administered by MA C;- 01/03/2026 at 8:00 p.m., the BP was 148/72 administered by MA C;- 01/04/2026 at 8:00 p.m., the BP was 148/80 administered by MA C;- 01/07/2026 at 8:00 p.m., the BP was 154/76 administered by MA C;- 01/08/2026 at 8:00 p.m., the BP was 148/76 administered by MA C;- 01/09/2026 at 8:00 p.m., the BP was 154/76 administered by MA C;- 01/03/2026 at 8:00 p.m., the BP was 133/77 administered by MA C;During observation and interview on 01/12/26 at 9:10 a.m. indicated Resident #75 was lying in hospital bed. Resident #75 was alert, and no signs of distress were noted. Resident #75 did not mention any concerns regarding her Clonidine when she was asked if she had any issues regarding her medications.In an interview and record review of Resident #75's MAR on 01/14/26 at 2:15 p.m. MA M stated the initials documented on 01/02/26 were her initials. The MA M stated the check mark documented the medication was given and should not have because Resident #75's systolic blood pressure (top number) was not greater than 160. MA M stated when the blood pressure was outside the ordered parameters it should not have been given. MA M stated if a medication was not administered it would be documented it was not given due to outside parameters. MA M stated the medication should not have been given on the dates. MA M said it was an oversight administering the B/P medications to Resident #75. MA M said she received in-services from the facility especially regarding medication administration, unnecessary medications, medication errors and that she received in-services at least monthly. MA M said a negative effect if a resident received a medication that was not accurate would be a medication error and the resident could have received a dose that was not needed.During an interview on 01/14/2026 at 2:30 p.m., the DON said her expectations were for all medications to be administered per physician orders including according to parameters. The DON said the Medication Aide or Nurse administering medications on the cart are responsible for following the physician orders written on the medication administration record. The DON said an adverse effect a resident could experience receiving a medication incorrectly would depend on the medication, but this failure could result in resident's blood pressure becoming lower.During an interview on 01/14/2026 at 2:40 p.m., the Administrator said his expectations were for all nursing staff to follow physician orders when administering medication to include following parameters. The administrator said an adverse effect a resident could have if not given the accurate dosage of medication was adverse side effects depending on the medication. The Administrator stated he expected medication to be administered as ordered without medication errors.During an interview on 01/14/2026 at 2:44 p.m., MA C said she should have held Resident #75's Clonidine medications as prescribed by the physician's parameter. She said if her initials were documented on the MAR, then the Clonidine was given and should not have been because the blood pressure was less than 160. MA C said it was ordered routine and to give it but that she should have read the order better. CM C said she had been educated and re-educated on administering medications with

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	455745	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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	455745	A. Building B. Wing	01/14/2026

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to ensure all medications were properly secured and stored in locked compartments for 1 of 4 medication carts (Hall 600) reviewed for medication storage. The facility failed to keep unattended medications secured by leaving it on top of a medication cart. This failure could put residents at risk for adverse reactions to medications and misappropriation of medications.Findings included:On 01/13/26 at 8:20 a, m., Surveyor N in the presence of another Surveyor (Surveyor G) observed MA K walked away from the medication cart, entered a resident's room, leaving a blister medication card of 10 white oval shaped pills and a small clear medication souffle cup of 4 pills (various colors and shape) on top of the medication cart. There were no staff or residents in the immediate area of the medication cart. At 8:23 a.m. MA K returned to the medication cart and continued her medication pass. MA K said she went to wash her hands.Observation on 01/13/26 from 8:23 a.m. to 8:40 a.m., MA K prepared and administered medications to 3 different residents in the 600 hall each time entering the rooms and turning her back to the medications (a blister medication card of 10 white oval shaped pills and a small clear medication souffle cup of 4 pills) on top of the locked medication cart. The medication on top of the cart was out of MA K's line of site. No staff or residents were seen in the hall.During an observation and interview on 01/13/26 at 8:43 a.m. MA K pulled the medication cart to the doorway of a resident's room, locked the cart, locked the electronic medical record and proceeded to walk away going into the medication storage room located behind the nurse's station (approximately 25 feet away from the medication cart) leaving the medication (blister card and souffle cup) on top of the cart and out of her visual sight. The medication cart was unattended during this time and a resident in a wheelchair was self-propelling his wheelchair next to the cart. Multiple staff members walked past the cart and attended to the resident. At 8:45 a.m. MA K returned to the medication cart and said she needed to get a carton of Glucerna and a bottle of multi-vitamin tablets from the medication room to continue her medication pass.During an interview on 01/13/26 at 8:45 a.m., Surveyor N questioned MA K if she should have left the medication on the cart, and MA K responded she should not have. MA K said she should have kept the medication she planned to administer in the locked medication cart while administering the first round of medications to Residents. MA K said the blister pack and the souffle cup of medications were for the same resident and was not in her view when she left to go to the medication storage room and the door had closed behind her. MA K said she had been in the storage room with the door shut and that she should not have left the medications on top of the cart because anyone could have taken them. MA K verified that the medication in the medication blister pack was 10 tablets of allopurinol (treats gout). MA K said she had a question about the medication, so she left it on top of her cart in the medication cup along with the blister pack so she wouldn't forget. MA K said she should not have left the medication on top of the medication cart unattended because someone could have taken the medication and it could have caused them to become sick or possibly die if allergic to it. MA K said she had been trained on medication storage, use and medication carts and to keep it locked when not in use. MA K said she just got busy and forgot.During an interview on 01/14/26 at 2:30 p.m., the DON said the nurses and MAs needed to maintain a view of the medication cart at all times and never walk away from the cart with medications left on top. The DON stated staff should never walk away with medications left on top of the cart for the safety of the residents. She further emphasized staff should not leave medications on top of the cart because a resident could come and take the medication off the cart and this could possibly cause harm to the resident. The DON said she was not sure why this occurred. The DON said she and the Administrator made rounds in the morning and several times a day and checked to see if the medication carts are locked if not in use and if meds are secured. The DON stated nurses and medication aides are trained on hire and PRN, on the use of medication carts, medication storage and security.During an interview on 01/14/26 at 2:40 p.m., the Administrator said he expected the medication cart to be locked when not in use or in line of sight. The Administrator acknowledged medications should never be left on top of a medication cart unattended because from a safety perspective, someone could come along and take it. The Administrator said if the medication cart was not locked, other people or residents could take something out of the cart that they did not need or possibly take a medication not intended for them. The Administrator said if a resident took a medication not intended for them, it could possibly cause a health issue for that resident.A review of the facility's Policy revised 05/22, for Medication Administration- Oral included that; .9. The medication card is to be kept in clear view and in reach of the person administering medications at all times it is to be locked when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455745	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberwood Nursing and Rehabilitation Center	4001 Hwy 59 North Livingston, TX 77351

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food under sanitary conditions in 1 of 1 preparation kitchen. * The facility did not ensure baking sheets did not have brown colored buildup on the outside edges.* The facility did not ensure muffin pans did not have brown colored buildup on the inside and outside edges.* The facility did not ensure skillets did not have brown colored buildup on the inside and outside.* The facility did not ensure skillets did not have the anti-stick coating flaking off. * The facility did not ensure steam table pans did not have brown colored buildup on the corner edges. These failures could place all residents who eat from the kitchen at risk for foodborne illnesses. Findings included: During an observation on 01/12/26 at 09:24 a.m. of the kitchen indicated the following:-3 muffin pans with dark brown food debris baked on outside and stacked together;-11 baking sheets with dark brown and/or black debris buildup baked on outside and inside stacked together; -3 skillets with dark brown build up outside; and-1 skillet with the interior anti-stick coating flaking off. During an interview on 01/12/26 at 09:26 a.m. the DM said DM said pans should be clean without debris buildup. She said the debris buildup could cause food borne illness. During an observation on 01/13/26 at 11:45 a.m. of the kitchen during the meal preparation indicated there were 3 large steam table pans with brown debris build up on top corner. Record review of an Infection Control Policy/Procedure for Dietary Services revised 05/2007 indicated .8. Dietary Housekeeping:.C. Dirty equipment should never touch food. D. All work surfaces, utensils, and equipment should be cleaned and sanitized after each use.Record review of The Food and Drug Administration Code at http://www.fda.gov/food/guidanceregulation accessed on 01/13/26 indicated the following: .4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils.(B)The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455745	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberwood Nursing and Rehabilitation Center	4001 Hwy 59 North Livingston, TX 77351

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 stove in the kitchen reviewed for essential equipment. * The facility did not ensure the gas stove was in safe operating condition. The front left burner and the left side oven on the stove would not ignite when the knobs were turned. This failure could place the residents at risk of a fire for not having safe operating equipment. Findings included:During an observation and interview on 01/13/26 at 11:45 a.m. left front burner on the stove would not light. The DM said the pilot light was out and she used a multipurpose lighter to light the burner. The left oven also would not light and the DM said she would have to light it with a lighter. The DM used a multipurpose lighter to light the oven. DM said the stove should light without using a lighter. She said having to light the stove with a lighter which could cause an explosion possibly causing injuries to residents. On 01/14/26 at 10:28 a.m. surveyor requested a policy regarding the functioning of the stove. Record review of the FDA Food Code 2022 accessed at https://www.fda.gov/food/retail-food-protection/fda-food-code 4-5 Maintenance and Operation4-501 Equipment4-501.11 Good Repair and Proper Adjustment.(A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. No policy regarding equipment maintenance and operation was provided prior to exit.