STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455800	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lev Attown Park	8820 Town Park Dr Houston, TX 77036

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15976 Based on interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (CR #1) of 5 residents reviewed for accuracy of assessments. The facility failed to ensure CR#1's behavior was coded on the quarterly MDS dated [DATE]. This failure could place residents with behavior at risk of not receiving care and intervention that could meet their behavioral needs. Findings included: Record review of CR #1's face sheet dated 05/16/2025 reflected CR#1 was a [AGE] year-old male who was admitted to the facility on [DATE] and discharged on [DATE]. CR#1's diagnoses included muscle wasting and atrophy (decrease or wasting of tissue, muscle or organs), lack of coordination (pattern walking or moving on foot), non- Alzheimer's disease (a type of dementia/neurodegenerative disease that affects the brain causing memory loss, confusion, and changes in behavior), hypertension (high blood pressure), diabetes (high blood sugar) hyperlipidemia (high levels of fat in the blood), seizure (uncontrolled jerking, loss of consciousness and blank stares), unspecified dementia (memory loss), and psychotic disorder (severe mental disorder that causes abnormal thinking and perception, lose touch with reality). Record review of CR#1's nurse's notes revealed the following. 4/2/2025 at 10:16am Resident observed in the hallway yelling and screaming help, when resident was asked what he needed resident began yelling out curse words towards the staff. Resident upset because he wanted to put the dirty clothes back on after his shower, staff attempted to redirect resident. This resident continued to yell out curse words calling the staff out calling them derogatory names. Resident continued to wheel himself up and down the hall yelling curse words to the top of his lungs. 4/2/2025 at 9:45pm Assisted the patient to bed and met all needs. The patient continued to shout loudly. Attempted redirection, but the patient was difficult to reorient and continued shouting. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/3/2025 at 09:42am. Patient up in w/c, able to make needs known, pt is verbally abusive towards staff during care, constantly cussing at staff for no reason. Pt at nursing station telling staff member he wished death to her kids and wished staff a car wreck. Pt not easily redirected, attempt to redirect, the more he cusses staffs. wheeled self to dining area at this time with no other concerns. 4/3/2025 at 09:26pm. Assisted the patient to bed and met all needs. The patient continued to shout loudly, repeatedly calling out one resident's name, causing disturbance to others. Attempted redirection, but the patient was difficult to reorient and continued shouting. 4/4/2025 at 06:35am. Resident was sitting up in bed upon shift rounding, attempting to get out of bed. Writer attempted to redirect him he got so agitated, and was using F-- words, and stating he wants his chair back. Writer was able to redirect him. Resident was assisted, with his pant, reassured him that I 'will be checking on him. Resident stable. Bed low, and locked safety precaution in place. 4/4/2025 at 09:51am Pt is up in w/c, able to make needs known. Non complaint with use of safe coffee cup. Pt prefers to use plastic drinking cups. cussing staff and insisting to use plastic cup for safety even after pt education on burns safety. no other concerns. 4/7/2025 at 9:54 pm The patient was in the wheelchair and repeatedly shouted profanities, including the use of FXXX, at the staff. Attempted redirection was made, but the patient continued to verbally abuse all staff members. As a result, staff were unable to assist the patient with getting to bed. 4/9/2025 at 5:56 am [CR #1] had a behavior this morning during care. He was cursing the aide during care using F- words. Record review of CR#1's quarterly MDS dated [DATE] revealed the following: Section C 500: CR #1 was coded as having a BIMS score of 14 indicating he was cognitively intact. Section E Potential Indicators of Psychosis: E100: Hallucination and delusional: he was coded, as having no hallucinations or delusion. E200: Behavioral Symptoms: Physical behavior, verbal behavior, and other behavioral symptoms such as (screaming, yelling and verbal/vocal) was coded as it did not happen. Record review of CR #1's comprehensive care plan dated 5/14/2025 reflected: Focus:CR#1 is resistive to care, refuses care at times: Goal: CR#1 will, cooperate with care through the next review Intervention: Allow CR#1 to make decision. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate resident/family caregiver of the possible outcome(s) of not complying with treatment or care. Praise the resident when behavior is appropriate. In an interview on 5/16/2025 at 1:45pm with SW C she said she worked with CR#1 and the staff reported he had behavior issues. She said she did not actually witness his behavior, but it was reported to her. She said she heard that he cursed the staff and his family member out. In an interview on 5/16/2025 at 2:00pm with RN B she said CR#1 was alert and oriented and could make his needs known. She said CR#1 had behavior of yelling and shouting and cursing at staff. In an interview on 5/16/2025 at 2:05pm Nurse Manager LVN A said that CR#1 had behavior of yelling and cursing at staff and his family member. She said CR#1 was alert and oriented and could make his needs known. She said there was an incident with CR#1 and his family member and CR#1 cursed the family member. In an interview on 5/16/2025 at 3:15 pm with RN P she said she worked with CR#1 and he was alert but sometimes he was delusional. She said sometimes the resident would be yelling and shouting and he would be telling them there were rats, snakes and racoons in his room. She said he screamed and cursed at the staff. In an interview on 5/16/2025 at 4:30pm with CNA B she said she worked with CR#1, and he cursed at the staff and his family member. She said sometimes he would be saying there were rats, snakes, and racoons in his room. In an interview with SW C on 5/16/2025 at 5.01 pm she said she was aware of CR #1 having behaviors. She said, however when she assessed CR#1 for the quarterly MDS CR#1 did not display any inappropriate behaviors and that was why she did not code CR#1's behavior section on the MDS as CR#1 having any behavior. Further interview with SW C revealed she did not check the nurse's notes or talk to the nurses and aides. In an interview on 5/16/2025 at 5:07pm with the DON she said her expectation of the nurses was to do proper assessment that included talking with the CNAs, and looking at the nurse's progress notes so they can capture all the changes of the resident. She said she will be in- servicing the staff (nurse and social worker) on reviewing nurses notes, CNA's documentations, and interviewing aides when they are completing the MDS. In an interview with MDS E on 5/16/2025 at 5:10pm she said she was made aware of the coding for behavior on the MDS and she was going to correct the MDS. She said that the different disciplines should look at the nurse's notes and the CNA's documentation before completing their section of the MDS. Record review of the MDS policy and procedures dated 2024 read in part . Policy: Residents are assessed, using a comprehensive assessment process, to identify care needs and to develop an interdisciplinary care plan. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Explanation and Compliance Guidelines: 1.According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State. 4. Care Plan Team Responsibility for Assessment Completion: Coding of Assessment: I All disciplines shall follow the guidelines in Chapter 3 of the current RAI Manual for coding each assessment.