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	11/17/2025

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's condition or need to alter treatment significantly for 1 of 10 residents (CR#1) reviewed for physician notification. 1. The facility failed to notify or seek medical guidance from the Medical Doctor or Nurse Practitioner for a change of condition after CR #1 complained of pain and a swollen knee on 11/5/25 at approximately 10:00pm. 2. The facility failed to immediately notify or seek medical guidance from the Medical Doctor or Nurse Practitioner after CR #1's left knee was observed swollen and painful at level 8 out of 10 (most severe) on 11/07/2025 at approximately 2:27 p.m, 3:41pm, and 4:18pm. 3. The facility failed to immediately seek medical guidance from the Medical Doctor or Nurse Practitioner for CR#1 after receiving results of an x-ray, which revealed, CR#1 had a Displaced distal femoral shaft spiral fracture. 4. The facility failed to immediately transport CR#1 to the hospital on [DATE] after becoming aware of the result of an x-ray, which reflected an acute fracture. The facility waited approximately 13 hours to transport CR#1 to the hospital, where CR#1 was diagnosed with a spiral fracture of his femur and required emergency surgery. An Immediate Jeopardy (IJ) was identified on 11/13/2025. The IJ template was provided to the facility (administrator) on 11/13/2025 at 1:00pm. While the IJ was removed on 11/15/2025 at 1:00am, the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could affect residents by placing them at risk of delayed treatment and continued severe pain. Findings included: Reviewed Record of CR#1's undated face sheet, revealed CR#1 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with active diagnosis of non-Alzheimer's Dementia (decline in cognitive function), and stroke (loss of blood flow in the brain). Reviewed Record of CR#1's Quarterly MDS (resident assessment) dated 8/11/2025 revealed CR#1's BIMS score of 00 indicated CR#1's cognition is severely impaired. The MDS further revealed CR#1 had severely impaired vision, he uses a wheelchair mobility resident totally dependent on staff for eating, oral and toileting hygiene, shower/bathing, upper and lower body dressing, personal care, and sit to lying in bed. Reviewed Record of CR#1's care plan dated 7/28/25 revealed the following:Focus: Resident has an alteration in hematological (clotting problem) status r/t receiving anticoagulant (Date Initiated: 7/21/25 and Revision 11/10/25).Goal: The resident will remain free of complications related to altered hematological (clotting problem) status through the review date (Date Initiated: 7/21/25, Revision date: 11/10/25, and Target date: 1/12/26).Interventions: Complete fall risk assessment and increase vigilance for falls (Date initiated: 7/21/25). Reviewed Record of CR#1's orders dated 7/28/25 revealed:-CR#1 is to be assessed for pain every shift (order dated 7/28/25 at 5:59pm-D/C dated 11/10/25 at 9:55am); PRN (as needed) -Acetaminophen (Tylenol) oral table 325 MG- Give 2 tablet by mouth every 6 hours as needed for pain/fever (order dated 7/28/25 at 5:59pm-D/C dated 11/10/25 at 9:55am); -Norco (Narcotic pain medication) Tablet 7.5-325 MG (PRN as needed)-Give 1 tablet by mouth every 8 hours as needed for pain (order dated 7/28/25 at 5:59pm-D/C dated 11/10/25 at 9:55am); -Biofreeze Cool the pain external Gel to apply to affected areas for pain PRN (as needed) (order date 11/7/25 at 4:49pm-D/C 11/10/25 9:55am); x-ray to left femur, left knee, and left tibial/fibula once only for pain (order date 11/7/25 at 4:51pm-D/C 11/10/25 at 9:55am). Record Review of MAR dates of 11/5/25 - 11/8/25 revealed, CR#1 was administered pain medications on 11/7/25 only. Reviewed Record of CR#1'nursing notes dated 11/6/2025 thru 11/7/2025, revealed no nursing notes regarding CR#1's complaint of pain regarding his knee nor was there an assessment for the night shift on 11/6/2025. Reviewed Record of CR#1's nursing notes dated 11/7/25 at 2:27pm revealed CR#1 was administered Norco (325mg) for a swollen knee and pain level 8. The note on 11/7/25 at 3:41pm revealed CR#1 was administered 2-Tylenols (650mg total) for pain level 8. The nursing notes on 11/7/25 created 5:46pm effective 5:00pm revealed LVN A noted a change in condition for CR#1 due to ineffective pain medication, and notification of NP was made. Record review of CR#1's pain assessment revealed the following: 11/7/25 at 8:07am Pain level 0 11/7/25 at 1:18pm Pain level 0 11/7/25 at 2:27pm Pain level 8 11/7/25 at 3:41pm Pain level 8 11/7/25 at 4:18pm Pain level 8 11/6/25 at 8:21am Pain level 0 11/6/25 at 2:26pm Pain level 0 11/6/25 at 10:51pm Pain level 0 11/5/25 at 8:37am Pain level 0 11/5/25 at 3:31pm Pain level 0 11/5/25 at 11:49pm Pain level 0 Record review the Radiology Results report dated 11/8/25 revealed a finding of: Displaced distal femoral shaft

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 that residents received treatment and care in accordance with professional standards of practice and the residents' choices for 1 of 10 residents (CR# 1) reviewed for quality of care. 1. The facility failed to immediately seek medical guidance or send CR#1 out for higher level of care (ER) after receiving results of CR#1's x-ray, which revealed a Left Displaced distal femoral shaft spiral fracture . 2. The facility failed to notify the physician or NP of CR#1's change in condition, failed to monitor, and complete assessments on 11/5/25 and 11/6/25. 3. The facility failed to immediately transport CR#1 to the hospital on [DATE] after becoming aware of the result of an xray, which reflected an acute fracture. The facility waited approximately 13 hours to transport CR#1 to the hospital, where CR#1 was diagnosed with a spiral fracture of his femur and required emergency surgery. These failures could place residents at risk for continued pain, serious injuries, harm and death to residents who require total supervision. An Immediate Jeopardy (IJ) was identified on 11/13/2025. The IJ template was provided to the facility (administrator) on 11/13/2025 at 1:00pm. While the IJ was removed on 11/15/2025 at 1:00am, the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems.Findings included: Reviewed Record of CR#1's undated face sheet, revealed CR#1 was a [AGE] year-old male initially admitted to the facility on [DATE] and re-admitted on [DATE] with active diagnosis of non-Alzheimer's Dementia (decline in cognitive function), and stroke (loss of blood flow in the brain). Reviewed Record of CR#1's Quarterly MDS (resident assessment) dated 8/11/2025 revealed CR#1's BIMS score of 00 indicated CR#1's cognition is severely impaired. 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