STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675078	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodway Nursing & Rehab	2808 Stoneybrook Drive Houston, TX 77063

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep confidential all information contained in the resident's records, regardless of the form or storage method of the records or safeguard medical record information against loss, destruction, or unauthorized use for 1 (Hall C) of 2 halls observed for privacy and failed to keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is to the individual, or their resident representative where permitted by applicable law or required by law for 1 (CR#1) of 1 residents reviewed for medical records. -CNA B left a computer logged into the medical record system unattended on 1/16/2025 at 10:52am.-The facility failed to respond to CR #1's representative's attempts for medical records requests on 5/21/2025, 6/24/2025, 7/9/2025, 7/22/2025 and 09/12/2025. This failure could place residents at risk of their personal health information being exposed to unauthorized personnel and could place residents and their representatives at risk of not being informed about their health status. Findings included:Observation and interview with OT A on 1/16/2026 at 10:52am, there was an unattended computer screen mounted to the wall of Hall C on which CNA B's name was shown on the top right of the screen and showed he was logged into the medical records system. OT A was walking by and was stopped and said CNA B should not have logged onto the computer and left it unattended because the medical records system contained private information with resident records and orders. OT A was observed logging out of CNA's account on the computer. There was no resident information on the screen.Interview with the ADON on 1/16/2026 at 10:58am, she said the computer should not have been left logged in and that she would start on verbal training for CNA B and then a facility-wide full-blown education later.Interview with the ADON on 1/16/2026 at 12:44pm, the ADON said that CNA B was hired three days ago and underwent all training before working. The ADON said that an unauthorized person could have gotten resident social security numbers, home address and diagnoses.Interview with the DON on 1/16/2026 at 12:26pm, she said CNA B should not have left the computer without logging out of the system, as unauthorized individuals could access resident information. The DON said staff get initial training and quarterly in-services on privacy.Interview with CNA B on 1/16/2026 at 1:20pm, CNA B said he left the computer to tell the ADON that his password worked. CNA B said he should not have done that, and someone could have located residents' home address or their diagnoses. CNA B said he received training on privacy at the facility.Interview with the Administrator, DON and ADON on 1/16/2026 at 1:35pm, the Administrator said the home screen CNA B logged into could not have given access to residents' medical records. The DON and ADON agreed to go back to the computer on Hall C and have a staff log in.Observation and interview with the DON and ADON on 1/16/2026 at 1:40pm, CNA M went back to the computer in Hall C and logged in. Once the screen was in the main screen, DON confirmed that from the home screen, staff did not need an additional password to access records. CR #1 Record review of letters (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
	675078	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodway Nursing & Rehab	2808 Stoneybrook Drive Houston, TX 77063

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	addressed to the facility's President/CEO with a different facility name and the same address as this facility:-Letter 1 was dated 05/21/2025 and contained certified mail and first-class mail from an entity representing CR#1 requesting medical records to be sent within 45 days. It contained an authorization form for protected health information requesting CR#1's entire record from 08/01/2024 to present and electronically signed by CR #1's RP. It listed CR #1's Certificate of Death dated 01/05/2025. It had CR #1's RP's state ID.-Letter 2 was dated 6/24/2025 with the same information. It was certified mail and first class mail.-Letter 3 was dated 7/9/2025 with the same information. It was certified mail and first class mail. Letter 3 had a scan of the certified mail envelope also dated 7/9/2025 addressed to this facility's physical address. When verified on USPS' website, it stated this letter had not reached its destination.-Letter 4 was dated 7/22/2025 with the same information. The PDF was labelled addressed and sent to the facility's Corporate Office; there was a scan of the certified mail envelope dated 07/22/2025. When verified on USPS' website, it stated this letter was returned to sender. -Letter 5 was dated 09/12/2025 with the same information. It also had a scan of the certified mail dated 09/21/2025 addressed to the facility's parent company. When verified on USPS' website, it stated this letter was received and signed by an individual at the postal facility. Record review of the facility's TULIP profile, on 4/1/2025 the facility had a name change. Per the Facility Summary Report, there was no change to the facility's parent company. The facility's status was effective 08/15/2025.Record review of CR #1's face sheet dated 1/16/2026, he was a [AGE] year-old male originally admitted on [DATE] and last re-admitted on [DATE]. His most recent hospitalization was 10/10/2024 to 11/29/2024. His medical diagnoses included: anemia, Parkinsonism, pressure ulcer of left hip (9/27/24), Alzheimer's Disease, quadriplegia, pressure ulcer of sacral region stage 4 (6/26/24), dysphagia, acute respiratory failure with hypoxia (11/29/2024) and pneumonia (11/29/2024). It listed CR #1's RP in the contacts section.Record review of the resident's progress notes, there were no notes documented before 09/27/2024.Record review of the resident's discharge MDS dated [DATE], he was discharged to the hospital on that date. CR #1's most recent Quarterly MDS dated [DATE] reflected CR#1 was rarely or never understood and a BIMS was not conducted. CR #1 was coded as having short-term and long-term memory problems and was totally dependent on staff for all ADLs.Interview with the SW on 1/16/2026 at 12:28pm, she had been at the facility since August 2022, and no one complained about not getting medical records. The process to request medical records was to speak to the medical records person, DON, Administrator. Then the facility would get a release form and let the resident or their representative sign it to get their medical record and that they're entitled to it.Interview with MR on 1/16/2026 at she came back to work in September 2025, and she did not hear about residents not getting requested documents. Residents and their representatives could verbally request from her, and she would just need to confirm the correct RP is making the request. There is also a form that residents and RPs could fill out. She said she was still in the process of learning about this position and if she had questions, she would ask the Administrator.Interview with BOM A on 1/16/2026 at 1:03pm, she said she oversaw accounts and authorizations and verifying eligibility. She denied receiving any medical records requests. BOM A said the new management took over on 4/1/2025, and they had a different name. BOM A did not remember CR #1.Interview with the former management company's BOM B on 1/16/2026 at 1:08pm, she looked into CR #1's records and found that he was admitted to the facility under the old company on 11/7/2023 and discharged [DATE]. She started working on 11/23/2024 and was not assigned to this facility until February 2025. She said she did not know this resident and had not received any medical records request from this resident or their RP. BOM B said if it was a former resident, she would send the request to whoever requested records to the local (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675078	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodway Nursing & Rehab	2808 Stoneybrook Drive Houston, TX 77063

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing homes' medical records.Interview with the Administrator, he said he started in his position one month ago. He said the process is for the DON to send medical records requests to the BOM. After some questioning, the Administrator stated a law firm did call him sometime in December 2025 and it was related to another resident under a different facility under the same management and it was not for this resident. He did not write down the name of the person he spoke to or their number. The Administrator said he did not know or recognize CR #1 and did not have the phone number of the former manager or the previous Administrator, He said if mail was addressed to the previous company, he would not sign the letters and that the letters would be sent back. He said the facility did not receive any mail or letters related to CR #1.Record review of the facility's policy on electronic medical records dated 2018, it read in part, 1. Electronic records are an acceptable form of medical record management. 2. The Administrator, in conjunction with the Quality Assessment and Assurance Committee, shall review requests for and the implementation of our electronic medical records system. 3. Only authorized people who have been issued a password and user ID code will be permitted access to the electronic medical records system. 4. The facility will make reasonable efforts to limit the use or disclosure of protected health information to only the minimum necessary to accomplish the intended purpose of the use or disclosure .Record review of the facility's policy on electronic medical records dated Qtr. 3, 2018 read in part, Policy Interpretation and Implementation 1. Electronic records are an acceptable form of medical record management. 2. The Administrator, in conjunction with the Quality Assessment and Assurance Committee, shall review requests for and the implementation of our electronic medical records system.Record review of the Texas Civil Practice and Remedies Code Section 74.051 verified on 05/26/2025 (found on https://texas.public.law/statutes/tex._civ._practice_and_remedies_code_section_74.051) read in part, .(a)Any person or his authorized agent asserting a health care liability claim shall give written notice of such claim by certified mail, return receipt requested, to each physician or health care provider against whom such claim is being made at least 60 days before the filing of a suit in any court of this state based upon a health care liability claim. The notice must be accompanied by the authorization form for release of protected health information as required under Section 74.052 (Authorization Form for Release of Protected Health Information) (d)All parties shall be entitled to obtain complete and unaltered copies of the patient's medical records from any other party within 45 days from the date of receipt of a written request for such records; provided, however, that the receipt of a medical authorization in the form required by Section 74.052 (Authorization Form for Release of Protected Health Information) executed by the claimant herein shall be considered compliance by the claimant with this subsection.Record review of the Texas Civil Practice and Remedies Code Section 74.052 verified on 05/26/2025 (found on https://texas.public.law/statutes/tex._civ._practice_and_remedies_code_section_74.052) read in part, (a) Notice of a health care claim under Section 74.051 (Notice) must be accompanied by a medical authorization in the form specified by this section .