

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2025
NAME OF PROVIDER OR SUPPLIER  Navasota Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1405 E Washington Navasota, TX 77868	

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 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, observation, and record review, the facility failed to ensure the residents had the right to be free from abuse and neglect for two (Resident #2 and Resident #5) of four residents reviewed for abuse and neglect. The facility failed to protect Resident #2 from physical abuse by Resident #5. This failure placed residents at risk of abuse, neglect, trauma, and psychosocial harm. Findings included: 1. Review of Resident #2's face sheet, dated 12/12/2025, reflected a [AGE] year-old male admitted on [DATE] with a diagnosis of major depressive disorder ( a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep or feelings of guilt), diarrhea, unspecified (a condition in which feces are discharged from the bowels frequently and in a liquid form), other depressive disorder, recurrent without psychotic features (someone having repeated, severe depression episodes but without delusions, meaning they stay grounded in reality). Review of Resident #2's Quarterly MDS, dated [DATE], reflected Resident #2 had a BIMS score of 15 indicating his cognition was intact. Resident #2 felt down, depressed, or hopeless 7-11 days out of the 14-day assessment period. He had trouble falling asleep or sleeping too much. He felt tired or had very little energy. Resident #2 had difficulty concentrating on things. Review of Resident #2's Comprehensive Care Plan with completion date of 09/25/2025, reflected Resident #2 had chronic diarrhea. Intervention: diet as tolerated. Give Anti-diarrheal medications. Monitor lab values and inform physicians of abnormal findings. Resident #2 had potential for alterations in mood related to depression. Interventions: Arrange for psych consult, follow up as indicated. Monitor/ document/ report to nurse/ MD of signs and symptoms of depression, including hopelessness, sadness, negative statements, tearfulness, etc. During an interview and observation on 12/12/2025 at 11:00 a.m., Resident #2 was in his room seated on his bed. He stated he had diarrhea and came out of the bathroom the day of the incident with Resident #5. He stated his roommate, Resident #5, told him to take a shower. Resident #2 stated he walked to the hallway and talked to CNA A about his shower. Resident #2 stated he asked if he could get a shower after his therapy. Resident #2 stated Resident #5 overheard the conversation between him and CNA A. Resident #2 stated when he went to the therapy room and sat in the chair, Resident #5 entered the therapy room cussing and yelling and very angry toward me. He stated the therapy staff attempted to talk to Resident #5 and Resident #5 continued to walk toward him. Resident #2 stated he informed Resident #5 if he thought he was big enough to fight him to come on and they would fight. Resident #2 stated Resident #5 approached him while he was sitting in the chair in therapy room and hit him in the nose. He stated there were therapy staff in the room and they tried to talk to Resident #5, and he became angrier. Resident #2 stated one therapist stood beside him for a few seconds, but no one tried to intervene when Resident #5 walked up and hit him in the nose. He stated there was not any staff who tried to protect him, but he was the one who threatened Resident #5 and Resident #5 threatened him. He stated it was just a hostile situation, and he believed if someone had gotten in front of him (Resident #2) he would not have been hit by Resident #5. Resident #2 stated he did not want to be near Resident #5 until he became calmer about the situation. He stated he would not harm Resident #5, but he was still upset over the situation. Resident #2 stated he had diarrhea because of the foods he ate, and he had history of diarrhea most of his life. He stated he did not eat the proper food, and his family brought food for him that hurt his stomach and caused diarrhea, but he did not report this to his family. Resident #2 stated his roommate stayed mad at him due to his diarrhea and the odor in the room. He stated this was the entire argument last week when he was hit by Resident #5 about the odor in his room and him not immediately taking a shower. Resident #2 stated he did see the psychiatrist after the incident with Resident #5, but she did not ask him any questions about the incident and him being mad toward Resident #5. Resident #2 stated he did feel safe at this facility and did not want to move to another facility or go anywhere else to live. 2. Review of Resident #5's face sheet, dated 12/12/2025, reflected a [AGE] year-old male resident admitted on [DATE] and readmitted on [DATE] with the following diagnoses bipolar disorder, current episode mixed, severe, with psychotic features ( Manic symptoms: high energy, racing thoughts , irritability, less need for sleep, rapid speech, and agitation. Depressive symptoms: sadness, loss of interest, low energy, and feelings of worthlessness. Psychotic features which involved losing touch with reality, Hallucinations seeing hearing or feeling things that are not there. Delusions: firmly held false beliefs believing you have superpowers or are being ruined) and generalized anxiety disorder (a mental health condition causing persistent excessive and</p>		

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F 0679  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide activities to meet all resident's needs.  (continued on next page)

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide an ongoing activity program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 3 of 59 residents reviewed for activities. The facility failed to provide activities for all residents in the facility for the entire months of August 2025 and September 2025. This failure could place residents at risks of boredom, depression, behavior, diminished quality of life and decreased cognitive function. Findings included:Record review of the activity participation record binder for the year of 2025 reflected there were not any participation records for the months of August 2025 and September of 2025. Record review of the QAPI, dated 12/08/2025, reflected the Activity Director and Activity Department were discussed and a plan developed. Review of Resident #2's face sheet, dated 12/12/2025, reflected a [AGE] year-old male admitted on [DATE] with a diagnosis of major depressive disorder ( a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep or feelings of guilt), diarrhea, unspecified ( a condition in which feces are discharged from the bowels frequently and in a liquid form), other depressive disorder, recurrent without psychotic features (someone having repeated , severe depression episodes but without delusions, meaning they stay grounded in reality).Review of Resident #2's Annual MDS, dated [DATE], reflected Resident #2 had a BIMS score of 15 indicating his cognition was intact. His activity preferences were the following: being around pets, going outside for fresh air when the weather was good, keeping up with the news, listening to music, and doing favorite activities. Review of Resident #2's Quarterly MDS, dated [DATE], reflected Resident #2 had a BIMS score of 15 indicating his cognition was intact. Resident #2 felt down, depressed, or hopeless 7-11 days out of the 14-day assessment period. He had trouble falling asleep or sleeping too much. He felt tired or had very little energy. Resident #2 had difficulty concentrating on things. Review of Resident #2's Comprehensive Care Plan with completion date of 09/25/2025, reflected Resident #2 had Problem initiated on 05/21/2025 Resident #2 had little or no activity involvement. Interventions: Establish and record the resident's level of activity involvement. Explain to Resident #2 the importance of social interaction, leisure activity time. Encourage Resident #2 to participate in activities. Interview on 12/12/2025 at 11:00 a.m. Resident #2 stated there were approximately two or three months where there were not many activities in the facility. He stated in the past 2 months there were activities daily. Resident #2 stated he was getting bored without anything to do except read and watch tv. He stated he enjoyed the socials and parties more than any other type of activities. Review of Resident #3's face sheet, dated 12/12/2025, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] had a diagnosis of mild intellectual abilities ( involves challenges with thinking, learning, and daily skills (like communication, self-care, and social skills) but allows individuals to learn practical life skills), major depressive disorder, recurrent severe without psychotic features ( causing significant life impairment such as work, social and self-care but without hallucinations or delusions- seeing hearing tasting or feeling things that seems real but isn't, having no external source), featuring symptoms like sadness, loss of pleasure, energy loss, and guilt), and generalized anxiety disorder ( a mental health condition causing persistent , excessive, and uncontrollable worry about everyday things).Review of Resident #3's Annual MDS, dated [DATE], reflected Resident #3 had a BIMS score of 15 indicating his cognition was intact. Resident #3's activity preferences was the following: have books to read, listen to music, keep up with news, doing things in groups of people, doing favorite activities, going outside to get fresh air when the weather was good, and participating in religious activities. Review of Resident #3's Comprehensive Care Plan, dated 09/03/2025, reflected Resident #3 needed out-of-room social, spiritual, and stimulus activities and mental stimulation. Intervention: Activity Director will encourage and remind resident of current activities. Interview on 12/12/2025 at 11:30 a.m., Resident #3 stated he liked to do activities on his own most of the time but liked to go to music and parties. He stated there were a few months where there were no activities except sometimes church. He stated for the past two months there were activities every day. Resident #3 stated he did not get bored because he had lots to do. He stated his family brought him things to do and he would sit in the dining room and do his own activity. Review of Resident #5's face sheet, dated 12/12/2025, reflected a [AGE] year-old male resident admitted on [DATE] and readmitted on [DATE] with the following diagnoses</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained as free of accidents and hazards as possible for 1 of 3 shower rooms reviewed for accidents and supervision. The facility failed to ensure the shower door located on Mc [NAME] Hall was closed and locked. This failure could place residents at risk of injuries, illness, and hospitalization. Findings included: Observation on 12/12/2025 at 10:15 a.m. revealed the shower room door on [NAME] Hallway was left opened and propped open 1 time. Observation revealed no staff or residents in the hallway or near the shower room. In the shower room there was no-rinse scented spray cleanser, shampoo and body wash, and shaving cream located on top of the clothes barrel. Interview on 12/12/2025 at 10: 20 a.m. CNA A stated he unlocked the shower room door and closed it when he exited the shower room to assist a resident to the shower room. He stated the door was closed when he left it unlocked. He stated he knew not to leave the shower room unlocked and it was required to be locked at all times. CNA A stated he was in-serviced on ensuring the shower room door was closed and locked at all times but did not recall the last time he was in-serviced on securing the shower room. CNA A stated if a resident drank the cleanser there was a possibility of becoming severely ill and, if a resident was allergic to the ingredients, the resident may die. Interview on 12/12/2025 at 10: 50 a.m., the Director of Nurses stated all shower doors were expected to be closed and locked at all times. She stated a resident may enter the shower room and close the door and would not know how to open the door to leave the shower room. She stated a resident may fall and have difficulty finding the call light to get nursing assistance. The DON stated death was a possibility if a resident ingested the cleanser. She stated there were not any residents on the [NAME] Hall who wandered into other residents' rooms or any room in the facility. Interview on 12/12/2025 at 1:05 p.m., the Administrator stated her expectation was for the shower door to remain closed and locked at all times. She stated there was a possibility a resident may fall into the shower room and be unable to reach the call light or yell for help. The Administrator stated if a resident ingested the cleanser there was a possibility the resident may need to be hospitalized , and it was possible a resident may die from the chemical. She stated the staff were in-service on locking and closing shower doors and keeping all chemicals locked. The Administrator did not remember the date or time of the most recent in-service. She stated it was everyone's responsibility to ensure the shower doors were locked and secured. She stated if any staff walked down the hall and saw a shower door opened, they were too close and ensured it was locked and report it to the DON. Record review of the Safety Data Sheet for the scented cleanser, not dated, reflected may cause eye damage or irritation. Skin Contact: if irritation develops, wash area with water. Get medical attention if irritation persists. Inhalation: treat symptomatically. Not expected to be toxic. Toxicological information: Ingestion may be harmful if swallowed. During an interview on 12/12/2025 at 1:05 p.m., the Administrator was asked for the Safety Data Sheet for the shaving cream, body and hair wash, which was not provided prior to exit. During an interview on 12/12/2025 at 1:05 p. m., the Administrator stated the facility did not have a protocol for Accidents and Hazards.</p>		

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.</p> <p>(continued on next page)</p>

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<p>F 0742</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, and record review , the facility failed to ensure a resident who was diagnosed with a mental illness or psychosocial adjustment difficulty, or who had a history of trauma and/or post-traumatic stress disorder, received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for four (Resident #1, Resident #2, and Resident #3 ) of five resident reviewed for behavioral health.The facility failed to ensure Resident #1, Resident #2, and Resident #3 received appropriate psychiatric services. This failure could place residents at risk because their mental and psychosocial needs not being met and a decreased quality of life. Findings included: Record review of Resident #1's Face Sheet, dated 12/12/2025, reflected a [AGE] year-old female admitted on [DATE] with diagnoses of anxiety disorder ( involves repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes with panic attack - a sudden, intense wave of extreme fear or discomfort that triggers severe physical and mental symptoms, like racing heart, shortness of breath, trembling, dizziness, and a feeling of losing control or dying), unspecified dementia, severe, with other behavioral disturbance (advanced dementia where cognition decline (memory thinking) is profound, impacting daily life significantly, and accompanied by disruptive behaviors like agitations, aggression, wandering, shouting often stemming from unmet needs or environmental triggers), and alcohol use, unspecified with alcohol-induced persisting dementia ( a type of cognitive decline from long-term heavy drinking, causing permanent brain damage, severe memory loss, impaired judgement, personality changes, and difficulty with thinking, learning, and coordination).Record review of Resident #1's Significant Change MDS , dated 05/02/2025, reflected Resident #1 had a BIMS score of 7 indicating her cognition was severely impaired. Resident #1 had disorganized thinking. She had difficulty focusing and was easily distracted. Resident #1 was assessed to have a diagnosis of anxiety disorder, Alcohol use, and not-traumatic brain dysfunction ( damage or impairment to the brain caused by internal factors such as : stroke - where blood flow to part of the brain stops - causing brain cells to die due to lack of oxygen - the body or its tissues aren't getting enough oxygen , tumors - abnormal mass of tissue from excessive cell growth, infections- invasion and growth of germs in the body, rather than an external blow to the head). Record review of Resident #1's Quarterly MDS Assessment, dated 12/02/2025, reflected Resident #1 had a BIMS score of 4 indicating her cognition was severely impaired. Resident had behavior of wandering ( 1 to 3 days per week). Resident was assessed to have a diagnosis of anxiety disorder, alcohol use, and not-traumatic brain dysfunction ( damage or impairment to the brain caused by internal factors such as : stroke - where blood flow to part of the brain stops- causing brain cells to die due to lack of oxygen- the body or its tissues aren't getting enough oxygen , tumors - abnormal mass of tissue from excessive cell growth, infections - invasion and growth of germs in the body, rather than an external blow to the head). Review of Resident #1's Comprehensive Care Plan dated, 10/27/2025, reflected Resident #1 had a history of trauma related to domestic violence that may have a negative impact initiated on 04/29/2025. Interventions, initiated 04/29/2025, included arrange Licensed Mental Health Provide as ordered by physician. Identify situation/ even/ images that trigger recollections of the traumatic event and limit the resident's exposure to these as much as possible. If the resident escalated, if at all possible, do not touch the resident unless absolutely necessary for resident's or others safety. Monitoring for escalating anxiety, depression, or suicidal thought and report immediately to the nurse. Problem initiated on 01/23/2025 and revised on 08/25/2025- Resident #1 had a behavior problem related to resident would eat soap from dispensers, history of removing water from toilet, and scooping into the trash can. She wanders into other rooms and rummages through other belongings. Attempt to assist and dictate the care of others. Resident #1 had history of lifting her shirt up and pants down to expose her breast and vagina to others. She had history of defecating on the floor. Resident #1 had history of returning from out of pass with family or friends with alcohol on breath and in her personal possession. She has urinated in the hallway and in other residents' rooms. She has hit glass doors when wanting attention. Interventions Resident had activity memory boxes made to help with distraction. If Resident #1exposes herself cover her and escort to her bedroom. Intervene as necessary. Approach Resident #1 and speak in a calm manner. Divert Resident #1's attention. Anticipate Resident #1's and meet her needs. Monitor Resident #1's behavior episodes and attempt to determine underlying causes. Consider Resident #1's location, time of day, people involved and situations. Document Resident #1's behavior and potential causes. Problem: initiated on</p>		