STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675399	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Navasota Nursing & Rehabilitation	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed ensure the comprehensive care plan, consistent with resident rights, included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for one of five residents (Resident #1) reviewed for care plans completion. The facility failed to ensure Resident #1's care plan was completed to reflect Resident #1 was lying on a mattress located on the floor and was crawling on the floor toward his roommate's bed. This failure could place residents at risk of not receiving appropriate interventions to meet their medical and safety needs. Findings include:Record review of Resident #1's face sheet, dated 03/04/2026, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with a diagnoses of Alzheimer's disease with late onset (a progressive brain disorder characterized by memory loss, confusion often influenced by a mix of genetics, environmental factors, and lifestyle), abnormalities of gait and mobility (deviations from normal walking patterns and reduced ability to move freely and safely), bipolar disorder, current episode depressed, severe, with psychotic features (a severe form where intense mood episodes are accompanied by a temporary loss of contact with reality, specifically hallucinations - sensory experiences or delusions - false, fixed beliefs), generalized muscle weakness (a widespread, non-localized reduction in physical strength affecting muscles throughout the body rather than one specific area), and cerebral infarction, unspecified (actual death of brain tissue due to lack of blood flow).Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Resident #1 was unable to complete the BIMS assessment. He had poor short- and long-term memory recall. His decision-making abilities was severely impaired. Resident #1 had difficulty focusing. He was easily distracted and had difficulty keeping track of what was being said. Resident #1 had disorganized thinking- rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject. Resident #1 was assessed to require supervision or touching assistance (helper provides verbal cues and/ or touching assistance as resident completes activity):EatingOral hygieneToileting hygieneUpper and lower body dressingPersonal hygieneTransfersRecord review of Resident #1's Comprehensive Care Plan dated 01/19/2026 and revised on 02/05/2026 did not reflect Resident #1 had mattress beside his bed and he would lie on the mattress and would crawl off the mattress toward roommate's bed.Record review of Resident #1's nurses notes dated 01/31/2026 at 3:35 a.m. read: upon entering room Resident #1 was found on mattress lying parallel with is bed. Record review of Resident #1's nurses notes dated 01/31/2026 at 4:00 a.m. read: upon entering room, resident noted lying on mattress on floor next to bed parallel with bed.Record review of Resident #1's nurses notes dated 01/31/2026 at 7:05 p.m. read: Resident #1 lying on mattress next to bed.Record review of Resident #1's nurses notes dated 01/31/2026 at 8:20 p.m. read: Resident #1 lying on mattress next to bed on floor.Record review of Resident #1's nurses notes dated 02/02/2026 4:46 p.m. reflected Resident #1 not staying on the mattress located on the floor. He crawled off the mattress two times. Resident #1 observed crawling toward roommate's bed.Record review of Resident #1's nurses notes dated 02/02/2026 at 11:58 p.m. reflected 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675399	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Navasota Nursing & Rehabilitation	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#1 rolled off the mattress onto floor and toward roommates' bed, awakening roommate. Record review of Resident #1's nurses notes dated 02/04/2026 at 1:20 p.m. reflected Resident #1 had a change of condition. He was placed on oxygen, and he was on hospice and respiratory rate was 28. Resident passed away at the facility and hospice was present on 02/04/2026.In an interview on 03/04/2026 at 11:50 a.m. the MDS Coordinator stated if Resident #1 had a mattress beside his bed and he was lying on the mattress and was crawling off the mattress toward roommates' bed; this behavior was expected to be care planned. She stated the purpose of having a Comprehensive Care Plan was to inform staff how to give the care each resident needed such as physical, behaviors, emotional, activities, type of diet and any other interventions to prevent falls or any injuries. The MDS Coordinator stated the nurses assigned to the residents was responsible for any new interventions with residents. She stated the nurses, social worker, activities, dietary manager, DON, and/or ADON was qualified to make any changes to a resident care plan. The MDS Coordinator stated all nursing staff had been in-serviced on how to enter any information on a resident's care plan. She stated she could not recall who gave the in-service or the date of the in-service. She stated she was responsible to monitor the care plans to ensure they were correct and completed on time. The MDS Coordinator stated the information the CNAs follows on Kardex came from the care plan. She stated if a resident needed certain type of care or had behaviors and it was not care planned, the CNAs would not have that information on their Kardex to know what type of care to give the residents.In an interview on 03/04/2026 at 12:40 p.m. The DON stated her expectations was the care plan to be revised as needed. She stated her date of hire at this facility was on 02/15/2026. The DON stated she had begun to review any issues in the morning meeting with all department heads (Administrator, MDS Coordinator, Social Worker, Activity Director, etc.) and maybe nurse supervisor. She stated the following was some of the issues discussed: if residents had a fall, any behaviors occurred over the past 24 hours, skin concerns, etc. The DON stated they did this twice a day in the morning meeting and afternoon meeting. She stated the group would make decisions on interventions for the resident and she expected MDS Coordinator to make changes on the care plan. She stated with a mattress being beside Resident #1's bed and he was lying on that mattress and was crawling to roommate's bed should have been care planned. She stated the care plan was a plan for all staff to know what type of care, needs, and resident preferences, of each resident in the facility. The DON stated if a resident had a specific preference, she expected that preference be care planned. She stated it was the nurses who worked directly with the residents, herself, ADON, or MDS coordinator to make changes to a resident's care plan. She stated the Kardex where CNAs reviews information of how to care for a resident comes from the resident's care plan. The DON stated if a resident had a change in ADLs and it was not care planned the CNAs may not know this information.In an interview on 03/04/2026 at 1:05 p.m. CNA/MA A stated Resident #1 had mattress on the floor by his bed approximately two weeks before he passed away at the facility. She stated she did not recall the date he passed away but it was the first week of February 2026. She stated she gave care to Resident #1, and he preferred lying on the mattress on the floor. She stated he began to crawl toward roommate's bed. CNA/MA A stated it was safer for Resident #1 to be on the mattress on the floor instead being in bed. She stated he frequently would roll out of bed. bed related to him would roll out of the bed. She stated she did not know who placed the mattress on the floor. CNA/MA A stated she did not recall seeing having a mattress beside his bed on the Kardex or about his behavior of crawling on the Kardex. She stated the Kardex was what the CNAs followed to know what type of care to give the residents. She stated she had been trained on how to use the Kardex, however, she did not recall the date. CNA/MA A stated if a new staff was working with Resident #1 and they reviewed his information on the Kardex the new staff may remove the mattress from the floor, and it was a possibility the resident would roll out of bed and have some type of injury such as broken bone or a cut on his head.In an interview on 03/04/2026 at 1:30 p.m. the Administrator stated her expectations of care plans was the IDT discuss care of each Resident and if there was a change with anything (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675399	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Navasota Nursing & Rehabilitation	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including resident preferences the care plan was expected to be revised. She sated if Resident #1 required a mattress beside his bed, this was expected to be care planned. She stated if the mattress was for his protection from an injury, it should have been on the care plan. She stated CNAs Kardex information came from the care plans and there was a possibility someone new working with Resident #1 or a new staff may not realize the reason the mattress was needed by his bed. She stated he was a fall risk, and he had a recent fall with injury. The Administrator stated she reported the injury and it had been investigated and was unsubstantiated. She stated the IDT was expected to ensure the residents information to give appropriate care to each resident was documented on the care plan whether it was physical, emotional, resident preference, activities, etc. The Administrator stated the charge nurse could make revisions to the care plan but ultimately it was the MDS Coordinators responsibility to ensure the care plan was completed and correct. She sated the IDT consisted of the following disciplines: DON, Social Worker, MDS Coordinator, Dietary Manager, Activity Director, Resident and Family. She stated staff had been in-serviced on how to document on the care plan; however, she did not recall the date of this in-service.In an interview on 03/04/2026 at 1:55 p.m. LVN B stated she had not been trained on how to document on a care plan. She stated she knew how to view a care plan; however, she did not know how to revise a care plan or enter a new problem on a care plan. LVN B stated she had worked at this facility over a year. She stated no one had in-service her about documenting anything on a care plan. LVN B stated care plans were very important for the staff to know what type of care to give a resident such as: ADLs, diet, what they preferred to do in activities, what interventions to use when resident is at risk for falls or have behaviors. She stated the information from the care plan would go on the CNAs Kardex on each resident. She stated if there were any changes with a resident she reported the change to the DON, ADON, family and Physician.In an interview on 03/04/2026 at 3:05 p.m. LVN C stated she had been trained on how to document on the care plan. She stated she worked at another facility owned by same company as this facility, and she was trained at the other facility. LVN C stated this was her first day to work at this facility. She stated at the other facility owned by same company as this facility did complete an in-service on how to document on a care plan. LVN C stated it was very important for a resident's care plan be changed if there were any changes with their ADLS, behaviors, or any type of interventions related to physical or emotional needs. She stated the information on the care plan was transferred over to the CNAs Kardex and that was how the CNAs knew what type of care to give a resident. Interview on 03/04/2026 at 3:30 p.m. the Nurse Consultant stated all nursing staff had been in serviced on how to document on care plans. She stated she did not know when they were in-serviced. The Nurse Consultant stated she did not have any documentation of nurses or any staff being in-service on how to document on care plans. (She did not respond to any other questions about care plans).Review of the facility's Comprehensive Care Plan, not dated, reflected The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS Assessment, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.