

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/31/2026
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure prompt efforts were made by the facility to resolve grievances for one (1) of five (5) Residents (Residents #1) reviewed for grievances, in that; The facility did not investigate or take prompt action to resolve grievances voiced by Resident #1's RP during a care plan meeting on 06/10/2026 regarding his wishes for Resident #1 not to be given morphine sulfate (narcotic pain reliever) unless he was first notified and that he would like to add a routine acetaminophen to take the edge off and prevent the use of morphine sulfate which caused the resident sedation and confusion. This deficient practice could place facility residents at risk of unresolved grievances, a decreased sense of self-worth, and a decline in quality of life. Findings Included: Review of Resident #1's face sheet dated 07/31/2026 reflected a 92- year -old female admitted to the facility on [DATE] diagnoses included Alzheimer's disease (progressive mental deterioration that can occur in middle or old age due to generalized degeneration of the brain), anemia (a deficiency of healthy red blood cells), pressure ulcer of right heel. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 3 which indicated severe cognitive impairment. Resident #1 rejected care one to three days a week. Resident #1 had unstageable pressure ulcers and did not have pain during the assessment period. Resident #1 was on hospice. Review of Resident #1's comprehensive care plan reflected a focus area [Resident#1] has chronic pain related to end stage disease process. Interventions included; Administer analgesia as per orders. Give 1/2 hour before treatments or care. Evaluate the effectiveness of pain interventions q shift and as needed. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Review of Resident #1's consolidated physician orders reflected an order dated 12/13/2024 for acetaminophen (OTC pain reliever) 500 mg one tab every 6 hours as needed for pain. Further review reflected an order dated 07/07/2025 for Morphine Sulfate (narcotic pain reliever) 15 mg every 4 hours as needed for pain (The order did not include any instruction for notification to family prior to administration.) Review of Resident #1's Care Plan conference dated 06/10/2026 reflected Resident #1's RP, MDS Coordinator, and DON were in attendance. The documentation reflected that the resident was not able to attend related to inability to comprehend due to impaired cognition. Further review of the care plan conference reflected .He reports that narcotic medication cause his mother to become sedated and confused. Son would like to add some routine acetaminophen for resident to see if it will aid in repositioning and take the edge off. He reports he would like to try it.Hospice will be contacted for orders. In an interview on 07/31/2026 at 11:22 am Resident #1's RP stated he had a care plan meeting with the facility in June and discussed with them his wishes regarding the use of Resident #1's Morphine Sulfate (MS). He stated he told them not to give it to her unless he was first notified (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675399
		If continuation sheet Page 1 of 4

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because if he needed to, he could be at the facility in a few minutes. He stated he never gets a follow up on any complaints he voices. He stated a nurse called him on 07/27/2026 that she was given the MS, but they did not call before. He stated that was how he knew they did not tell the nurses his wishes. Review of the facility's grievance log dated June 2026 reflected no entries for Resident #1. Observation and interview on 07/31/2026 at 10:20 am revealed Resident #1 in her room in bed. She was getting bed bath from a hospice aide. She stated she was very good, stated she was not in pain and stated her pain was ok. Review of Resident #1's MAR reflected she was given MS once on 7/27/2026. Resident #1's medical record reflected no documentation that her RP was notified. In an interview on 07/31/2026 at 12:44 pm, RN A stated she worked with Resident #1. She stated she has given Resident #1 her MS when she was having pain. She stated she was unaware the family wanted to be notified prior to administration. She stated it was not documented anywhere in her medical record to call the family prior to MS administration. In an interview on 07/31/2026 at 12:58 pm, the MDS Coordinator stated she did the care plan meeting. She stated when a resident's family had complaints during the meetings they would do a grievance form and give to who it needs to go to. She stated if order changes were needed then it would go to the nurse to call the doctor. She stated she would follow up to make sure it was done. She stated they have had several care plan meetings with Resident #1's RP. She stated any special instructions should be put in the resident's medical record. The MDS Coordinator stated after reviewing Resident #1's medical record the instructions for the RP to be notified prior to MS administration was not in Resident #1's record and it should have been. She stated Resident #1's RP complaints during the care plan meeting should have been translated into a grievance and should have been followed up on, but she did not follow up. She stated she did not usually do the follow up but she would do the grievances. She stated she did not do a grievance regarding this one. She stated she contacted hospice for orders but did not follow up to ensure they were carried out. In an interview on 07/31/2026 at 2:41 pm, the DON stated she did not follow up on the complaints from Resident #1's RP that were voiced during the care plan meeting in June. She stated she recalled talking about the resident's medication but did not recall exactly was discussed. She stated it would have been her responsibility to follow up but she did not. In an interview on 07/31/2026 at 3:15 pm, the RNC stated that when residents or residents families voice concerns at any time not just in care plan meetings the grievance process should be used to ensure the ones who are responsible for addressing the issue follow up to ensure the issues are addressed. Review of the facility's grievance policy dated 11/02/2016 reflected The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have.		

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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 to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for one of five residents (Resident #1) reviewed for care plans. The facility failed to revise a comprehensive care plan to reflect Resident #1's RP's wishes for her pain medication administration. These failures could place residents at risk of not receiving appropriate interventions to meet their psychosocial and medical needs. Finding included: Review of Resident #1's face sheet dated 07/31/2026 reflected a [AGE] year-old female admitted to the facility on [DATE] diagnoses included Alzheimer's disease (progressive mental deterioration that can occur in middle or old age due to generalized degeneration of the brain), anemia (a deficiency of healthy red blood cells), pressure ulcer of right heel. Review of Resident #1's quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 3 indicating severe cognitive impairment. Resident #1 rejected care one to three days a week. Resident #1 had unstageable pressure ulcers and did not have pain during the assessment period. Resident #1 was on hospice. Review of Resident #1's Care Plan conference dated 06/10/2026 reflected Resident #1's RP, MDS Coordinator, and DON were in attendance. The documentation reflected that the resident was not able to attend related to inability to comprehend due to impaired cognition. Further review of the care plan conference reflected .He reports that narcotic medicaiton cause his mother to become sedated and confused. Son would like to add some routine acetaminophen for the resident to see if it will aid in repositioning and take the edge off. He reports he would like to try it.Hospice will be contacted for orders. In an interview on 07/31/2026 at 11:22 am, Resident #1's RP stated he had a care plan meeting with the facility in June and discussed with them his wishes regarding the use of Resident #1's Morphine Sulfate (MS). He stated he told them not to give it to her unless he was first notified because if he needed to, he could be at the facility in a few minutes. He stated he never gets a follow up on any complaints he voices. He stated a nurse called him on 07/27/2026 that she was given the MS, but they did not call before. He stated the is how he knew they did not tell the nurses his wishes. Review of Resident #1's comprehensive care plan reflected a focus area [Resident#1] has chronic pain related to end stage disease process. Interventions included; Administer analgesia as per orders. Give 1/2 hour before treatments or care. Evaluate the effectiveness of pain interventions q shift and as needed. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. The care plan did not the Resident #1's RP wishes for care. In an interview on 07/31/2026 at 12:58 pm, the MDS Coordinator stated she did the care plan meetings. She stated when residents families had complaints during the meetings they would do a grievance form and give to who it needs to go to. She stated if order changes were needed they would go to the nurse to call the doctor. She stated she would follow up to make sure it was done. She stated they have had several care plan meetings with Resident #1's RP. She stated any special instructions should be put in the resident's medical record. The MDS Coordinator stated after reviewing Resident #1's medical record the instructions for the RP to be notified prior to MS administration was not in Resident #1's record and should have been. She stated Resident #1's care plan should have been updated to reflect the Resident's RP wishes. In an interview on 07/31/2026 at 3:15 pm, the RNC stated that when residents or residents families voiced (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concerns at any time not just in care plan meetings, the grievance process should be used to ensure the ones who are responsible for addressing the issue follow up to ensure the issues are addressed and the care plan should be updated. Review of the facility's undated policy comprehensive care planning reflected The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Through the care planning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the residents' preferences, choices and goals during their stay at the facility. The facility will establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives.		