

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

Printed: 02/25/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Sugar Land Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 333 Matlage Way Sugar Land, TX 77478	
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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a nurse aide was able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for one (CR #2) of five residents reviewed for assistance with meals. -An unidentified staff supported CR #2's food dish on the staff's lap as she fed the resident. The failure placed the resident at risk for acquiring food-borne illness. Findings include: Record review of the admission Record for CR #2 revealed he was [AGE] years old, admitted to the facility on [DATE]. Diagnoses included dysphagia (difficulty swallowing), lack of coordination, and muscle weakness. He was discharged from the facility on 08/08/2025. Record review of CR #2's 5-day admission MDS assessment dated [DATE] revealed, he exhibited severely impaired cognition. He had impaired range-of-motion to both upper and lower extremities. He was dependent on staff for eating assistance. In an interview via telephone on 12/17/2025 at 1:23 p.m., CR #2's family member verbalized concern that a staff member fed CR #2's meal while having the resident's plate of food on her lap. She said she would send a video. The family member gave consent for the surveyor to show the video to the facility. Review of the video dated 08/02/2025 at 1:11 p.m., revealed an unidentified staff member in a chair, next to CR #2's bed. CR #2 was lying in bed and the unidentified staff member had the resident's food dish on her lap. After she stirred and chopped at the food with a utensil, the staff fed CR #2. The resident's over-bed table was in front of the staff member. Interview and record review on 12/17/25 at 3:30 p.m., the DON viewed the video. He said the technique exhibited by the staff feeding the resident with the resident's plate on her lap was Not OK. He said the plate should not have been in her lap. He noted that the over-bed table was in front of the staff. He said the technique was an infection control issue. He did not identify the staff member but did acknowledge CR #2 resided at the facility on that date and the room was that of the facility. Observation on 12/17/2025 at 12:19 p.m. revealed CNA G assisting Resident # 3 with her meal. The tray was on the over bed table. Observation on 12/17/2025 at 12:22 p.m. revealed Resident #4's tray was on the over bed table, in front of the resident. Observation on 12/17/2025 at 12:30 p.m. revealed an unidentified staff assisting Resident #5 with her meal. The tray was on the over bed table. The facility did not provide a policy regarding staff assistance with meals but did provide a blank copy of the CNA skills check list that included feeding residents.		

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: 675538
		If continuation sheet Page 1 of 3

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of 1 (CR #1) of 4 residents reviewed for pharmacy services.-CR #1's hospital discharge orders were not transcribed properly to the resident's facility admission orders. CR #1 did not receive the correct dose of Divalproex Sodium.This failure could result in CR #1 not receiving the correct dose of anti-seizure medication.Findings include: Review of the admission Record for CR #1 revealed she was [AGE] years old and was admitted to the facility on [DATE]. Diagnoses included Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures (seizure disorder), cerebral infarction (condition where blood flow to a part of the brain is disrupted, resulting in brain-tissue death), and hypertension (high blood pressure). She was discharged from the facility on 07/04/2025.Review of CR #1's 5-day Entry MDS assessment dated [DATE] revealed the resident scored 11/15 on the BIMS, indicative of moderate cognitive impairment. The resident exhibited little or no interest or pleasure doing things, had difficulty falling or staying asleep (or sleeping too much), and felt tired or had no energy.Review of CR #1's hospital Discharge Orders dated 06/14/2025 revealed she was receiving Divalproex Sodium ER (medication to treat Epilepsy/seizures) 1000 mg, twice daily.Review of CR #1's Physician's Order dated 06/14/2025 revealed Divalproex Sodium ER oral tablet Extended Release 24 hour 250 MG. to be administered every 12 hours for seizures. The order was transcribed by LVN B.Review of CR #1's Physician's PN dated 06/17/2025 at 08:18 a.m., revealed Physician A documented he saw the resident at the facility on that date. The PN reflected the resident was receiving 50 mg of Depakote ER (generic form of Divalproex Sodium ER) twice daily, instead of 1000 mg twice daily as reflected in the hospital discharge summary or 250 mg every 12 hours, as reflected in the facility Physician Order dated 06/14/2025. The PN reflected no correction of the Physician Order dated 06/14/2025. Review of CR #1's June 2025 MAR revealed she received one 250 mg tablet of Divalproex Sodium ER every 12 hours from 06/14/2025 at 9:00 p.m. to 06/30/2025 at 9:00 p.m. Review of CR #1's July MAR revealed she received one 250 mg tablet of Divalproex Sodium ER every 12 hours from 07/01/2025 to 07/04/2025 at 9:00 a.m. (date of discharge).In an interview on 12/17/2025 at 2:44 p.m., LVN B said the procedure for new admissions was to call or text the physician or NP that the resident had arrived and ask them to review medications. If there was a change, the physician or NP was to notify the nurse via phone, text, or in person. She said the medication orders were not to be entered into the system without approval. When asked if the verification was to be documented, she responded there was no protocol, so she did not document in every case. She said she would have verified the orders with NP C. She said she could not remember if NP C changed any of the orders. In an interview via telephone on 12/17/2025 at 3:12 p.m., CR #1's family member said when the resident was discharged , he noticed the facility had been administering one 250 mg tablet of Divalproex Sodium ER twice daily, instead of 1000 mg twice daily, as reflected in the hospital discharge orders. He said after the resident was discharged from the facility she would scream 'Help me!' all day. She was admitted to a different facility and passed away on 11/22/2025.In an interview on 12/17/2025 at 3:30 p.m., the DON said there was no set way for the nurses to verify new admission orders, but the nurse could call, text, or use an app. The nurse was to contact the NP or doctor, give report, and have them reconcile the medications. He said the nurse should chart that they contacted the physician. The DON said if the medications were not verified, it could result in a medication error. He said he did not know if NP C changed CR #1's Divalproex Sodium ER order upon admission.In an interview via telephone on 12/17/2025 at 4:42 p.m., NP C said she looked through her texts and said she received CR #1's medication list from the hospital. She said she told the nurse to continue with all of the medications. She said she does not review medications but tells the nurse to continue the hospital medications. When asked what complications could arise from the resident receiving 250 mg of Divalproex Sodium ER twice daily versus 1000 mg Divalproex Sodium twice daily, she said she did not want to answer that.In an interview via telephone on 12/17/2025 at 5:15 p.m., Physician A was asked what complications could arise from the resident receiving 250 mg of Divalproex Sodium ER twice daily versus 1000 mg Divalproex Sodium twice daily. He said it would depend on what other medications the resident was on. He said the resident also had low sodium levels, which could have caused altered mental status. The facility policy admission Orders (Revised 02/01/2023) read in part A physician must personally approve in writing a recommendation that		