STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview, and record review the facility failed to ensure the resident had the right to be treated with respect and dignity for 1 of 8 residents (Resident #1) reviewed for dignity. - The facility failed to timely empty Resident #80's urinal timely resulting in it backflowing on the resident and the resident emptying it in the trash can at his bedside. This failure could place residents at risk of feeling uncomfortable and disrespected. Findings included: Record review of Resident #80's face sheet dated 04/11/25 revealed, an [AGE] year-old male who admitted to the facility on [DATE] with diagnosis which included: muscle weakness, age related physical debility, and Alzheimer's disease. Record review of Resident #80's Admission MDS dated [DATE] revealed, moderately impaired cognition as indicated by a BIMS score of 10 out of 15, no rejection of care, no verbal or physical behavioral problems, substantial assistance with toileting hygiene and upper body dressing. Resident #80 was not on a toileting program (scheduled toileting, prompted voiding or bladder training), and was always continent of both bladder and bowel. Record review of Resident #80's undated care plan revealed, focus- limited physical mobility or risk for decline with mobility related to impaired mobility and weakness; goal- participate in ADLs to his ability. (continued on next page)

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
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 04/08/25 at 09:10 AM revealed, Resident #80 in bed. There was a male urinal on his bed side table with a small amount of dark yellow fluid, and dark yellow fluid was observed in the bedside trash can. Resident #80 said sometimes staff were slow to respond to his call light or providing services especially when it came to his urinal. He said the staff did not empty his urinal often so he was forced to dump it in a cup in his trash can and sometimes he missed which made staff upset with him. Resident #80 said he dumped his urine into the trash can because he could not use his urinal when it was high because it would backflow onto him. Resident #80 placed a finger on his urinal at approximately 1/4 full to indicate what volume of fluid the container held when it began to backflow on him if used. Resident #80 said has urinal was on top of his bedside table because he had nowhere else to place it. An observation and interview on 04/11/23 at 07:45 AM revealed, Resident #80 in his room with his urinal 1/8 full, no liquid was observed in his trash can. Resident #80 said he notified the facility when his urinal was approximately 1/4 full. He said at 1/4 full it had to be emptied if not it would backflow on him when he used it, which he did not like. In an interview on 04/11/25 at 07:51 AM, CNA A said she cared for Resident #80. She said Resident #80 would pour urine into a Styrofoam cup provided for water and place it in his trash can, but she had not asked the resident why he did this. She said the facility did not require urinals to be emptied at any frequency or at any particular volume, but they should be emptied urinals whenever they needed to be emptied. CNA A said both nurses and CNAs are responsible for emptying resident urinal, and she herself emptied resident urinals every hour. She said urinals should be emptied timely to prevent cross contamination and prevent bacteria growth. In an interview on 04/11/25 at 04/11/25 at 08:38 AM, LVN C said Resident #80 liked to keep his urinal at his bedside table. She said the resident's behaviors included emptying his urinal into a cup in his trash can and sometimes It would spill. LVN C said when the urine spilled the resident would get aggravated. She said resident did not always use his call bell when he needed his urinal emptied so she emptied it when was in his room. LVN C said it was the responsibility of all nursing staff to empty residents' urinals when they were in the resident's room providing care and the facility did not have a particular frequency. She said she had not received any complaints from the resident regarding delays in emptying his urinal or it backflowing on him. LVN C said failure to promptly empty a resident's urinal could place them at risk of spilling it on themselves leading to skin irritation and the resident might not like it. In an interview on 04/11/25 at 12:26 PM, the DON said resident urinals are usually kept at their bedside, on the nightstand, or drawer handle so they are easily accessible. She said CNAs and Nurses round on residents frequently and they are expected to empty urinals when they are half full or less and placed within reach of the resident. The DON said the facility does not have a specified frequency to which urinals should be emptied as it depended on the resident's pattern, but staff are expected to check on residents at least every 2 hours. She said failure to empty a resident's urinal frequently could result in spills during use, odors and leave the resident not too happy. The DON said she had not heard about Resident #80 emptying his urinal into a cup in the trash can, and if such behaviors existed it should have been documented in the resident's chart. On 04/02/25 at 12:26 PM, at the end of an interview a request was made to the DON for the facility policy on incontinence care. The policy was not provided prior to exit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the undated facility policy Resident Rights revealed, The resident has the right to a dignified existence. 4- Respect and dignity, the resident has a right to be treated with respect and dignity. Record review of the undated facility policy Promoting/Maintaining Resident Dignity revealed, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Compliance guidelines: 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights. 2. During interactions with residents, staff must report, document and act upon information regarding resident preferences. 4. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. 43049 Based on interview and record review, the facility failed to ensure the resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for 1 (Saturday) of 6 mail delivery days reviewed for privacy. - The facility failed to ensure mail was delivered within 24 hours to residents on Saturdays. This failure could place residents at risk of not receiving mail in a timely manner that could result in a decline in the resident's well-being, quality of life and cause them to feel disconnected from family, friends, and current world issues. Findings included: During a confidential group interview on 04/09/25, four of four residents identified by the facility as being alert, oriented and interviewable, revealed that mail was not delivered on Saturday. In an interview on 04/09/25 at 01:30 PM, the Administrator said the facility delivered mail to residents on the weekend. He said on Saturday it was the responsibility of the weekend receptionist and the Managers on Duty to ensure that residents received their mail. The Administrator said the MODs rotated who worked on the weekend and they consisted of the MDS Nurse, Administrator, Business office Manager, Activity Director, and the HR Staff. In an interview on 04/09/25 at 01:32 PM, the Activities Director said she had worked for the facility for 4 years and worked alternating weekends as a MOD. She said she did not know where mail was kept and ensuring residents received mail on the weekend was not one of the assigned duties of the MOD. In an interview on 04/09/25 at 01:35 PM, the HR staff said she had worked in the facility since 1989 and worked as a MOD on alternating weekends. She said passing mail on the weekend was the responsibility of the receptions because she did not go to the lobby area. She said ensuring residents received mail on the weekend was not one of the MOD's responsibilities. In an interview on 04/09/25 at 01:43, the Receptionist said she worked as the receptionist on some weekends, and she never passed out mail. She said the other weekend receptionist was new and she did not pass out mail either because she did not know where the mail went. She said it was the facility's policy/procedure to hold mail that arrived on Saturday to be delivered with Monday's mail. In an interview on 04/09/25 at 01:45 PM, the Social Worker said she had worked for the facility for 4 months. She said she was a MOD on alternating weekends, and she had never delivered mail. The social worker said she had not received any education from administration that mail had to be delivered on the weekend. In an interview on 04/11/25 at 01:08 PM, the Administrator said there were no physical risk to residents if they did not receive their mail on Saturday. He said the failure to deliver mail on Saturday could result in an emotional risk of resident's feeling like they are being let down. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the undated facility policy Mail and Electronic Communication revealed, 4- mail and packages will be delivered to the resident within 72 hours of delivery on premises or to the facility's post office box (including Saturday deliveries).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observations, interviews, and record review, the facility failed to ensure residents had a safe and homelike environment, including but not limited to receiving treatment and support for daily living safely for 1 of 8 residents reviewed (Resident #62) reviewed for a homelike environment. - The facility failed to ensure the bump rail located by window of Resident #62's room was attached to the wall without nails sticking out and the wall trim was not missing. This failure could place residents at risk of decreased feelings of self-worth, emotional destress, and physical injury. Findings included: Record review of Resident #62's Face Sheet revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: muscle weakness, lack of coordination, anxiety disorder and mild intellectual disabilities. Record review of Resident #62's Quarterly MDS dated [DATE] revealed, moderately impaired cognition as indicated by a BIMS score of 12 out of 15. She had no hallucinations, no physical or verbal behavioral symptoms, no rejection of care, no wandering behaviors and used a walker. Record review of Resident #62's undated Care Plan revealed, focus- resident wished to continue to reside at the facility for long term care. Focus- psychosocial (social factors that impact a person's mind) problem related to depression; intervention- encourage participation and involvement in resident's preferred, scheduled, and alternate activities offered in the facility. An observation and interview on 04/08/25 at 09:30 AM revealed, Resident #62 sitting in bed. The resident was well dressed, well-groomed and in no immediate distress. She said her room needed improvement and pointed out the missing trim close to the floor and a dislodged bump rail with 3 nails sticking out at the bottom of the wall by her roommate's bed. She said she reported the missing trim and broken bump rail to social services and the DON , but nothing was done. She said she understood that to the staff this was just a job but to her and others this was their home, and it should not be like that. In an interview on 04/09/25 at 11:00 AM, the Administrator said there were no associated grievances from Resident #62 regarding repairs to the trim or bump rail in her room and he was never notified In an interview on 04/09/25 at 11:05 AM, the Administrator said he walked the facility with the Maintenance Director Weekly. He said the weekly inspection involved checking all resident rooms from ceiling to floor to identify any necessary repairs. The Administrator said any identified issues were entered into the facility maintenance system and then immediately repaired. He said he performed the weekly walk last Tuesday(04/02/25) and this was the first time he saw the dislodged bump rail so it must have just happened. The Administrator said the dislodged bump rails with the exposed nails could place residents at risk for wounds or injuries. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/09/25 at 01:47 PM, the Maintenance Director said he rounds on resident rooms twice a week to ensure all rooms are in good order. He said facility was the residents' home, so he wanted them to be happy and comfortable. He said he last did rounds in resident rooms last Thursday (04/03/25) and the bump rail in room [ROOM NUMBER] was not dislodged. The Maintenance Director said all bump rails/chair rails were expected to be secured to the wall and the dislodged bump rail with exposed nails was a safety issue because residents could cut themselves. In an interview on 04/10/25 at 09:30 AM, Resident #62 said the trim and bump rail was dislodged from out of the wall since she started living in the facility a year ago. She said she notified the Administrator but not action had been taken. Record review of the undated facility policy titled Environmental Services Inspection revealed, it is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis. 1. The Director of Environmental Services will perform random and/or routine inspections. 2. All opportunities will be corrected immediately by environmental services personnel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview, and record review the facility failed to accurately assess each resident's status for 2 of 8 resident (Resident #57 and Resident #68) reviewed for accuracy of assessments. - The facility failed to document Resident #57s lower extremity impairment in the resident's Quarterly MDS - The facility failed to document Resident #68's use of corrective lenses in the resident's quarterly MDS This failure could place residents at risk of inaccurate assessments, which could compromise their plan of care . Findings included: Resident #57 Record review of Resident #57's Face Sheet dated 04/09/25 revealed, an [AGE] year-old female who admitted to the facility on [DATE] with diagnosis which included: muscle wasting, muscle weakness, lack of coordination, depression, and other reduced mobility. Record review of Resident #57's Admission MDS dated [DATE] revealed, resident was rarely/never understood, rarely/never understood others, had severely impaired vision. She had moderately impaired cognitive skills for daily decision making and had an acute onset mental status change as indicated by inattention, disorganized thinking, and altered level of consciousness. The resident's functional abilities such as roll left to right, sit to lying sit to stand and transfers could not be assessed due to her medical condition or a safety concern. The MDS said Resident #57 did not have an upper extremity (shoulder, elbow, wrist, hand) or lower extremity (hip, knee, elbow, wrist, hand) impairment. Record review of Resident #57's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 00 out of 00, rarely/never understood others, rare/never makes self-understood, had signs and symptoms of delirium(a state of confusion due to medical conditions) which included inattention and altered level of consciousness. Resident #57's was dependent on staff to roll from her back to the left and right side, and she could not be assessed for her ability to move from sit to lying, sit to stand, transfer herself or walk due to her medical conditions or safety concern. The MDS said Resident #57 did not have a upper extremity (shoulder, elbow, wrist, hand) or lower extremity (hip, knee, elbow, wrist, hand) impairment. Record review of Resident #57's Undated Care Plan revealed, Focus- resident wears Glasses due to Glaucoma(group of eye conditions that damage nerves in the eye that can lead to vision loss and blindness). Focus- resident is hard of hearing and wears hearing aids on both ears. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 04/08/25 at 09:35 AM revealed, Resident #57 in bed well dressed, well-groomed in no immediate distress. The resident was on her left side, with legs contracted below her knees and pillows/wedges were placed around her. Resident #57 was non-responsive to the surveyor, looked at the ceiling and did not respond to the surveyors prompts or presence. An observation on 04/09/25 at 10:30 AM with the Wound Care Nurse revealed, Resident #57 lying on her left side. Both of the resident's knees were contracted and she had a pillow between her knees, bilateral (both sides) heal protection boots and the Wound Care Nurse placed a wedge behind the resident's back. In an interview on 04/10/25 at 09:32 AM, LVN B said she was Resident #57's admitting nurse in December of 2024 and when the resident arrived, she was bedbound, lying on her left side with bilateral (both sides) contractures to her lower extremity. In an interview on 04/10/25 at 09:55 AM, the Wound Care Nurse said when Resident #57 admitted to the facility in December of 2024 she had lower extremity contractures. Resident #68 Record review of Resident #68's Face Sheet dated 04/10/25 revealed, an [AGE] year-old man who admitted to the facility on [DATE] with diagnosis which included: high cholesterol, high blood pressure, unsteadiness on feet and a history of falling. Record review of Resident #68s Quarterly MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 13 out of 15, moderate difficulty hearing with the use of hearing aids and impaired vision with no corrective lenses. Record review of Resident #68's undated Care Plan revealed, Focus- hard of hearing and wears hearing aids on both ears, intervention- encourage resident to wear hearing aids daily to promote good communication. Focus: impaired visual function wears glasses related to glaucoma (a group of eye diseases that damage the nerve in the eye that carries information from the eye to the brain). An observation on 04/11/25 at 09:20 AM revealed, Resident #68 in his wheelchair by his bed. The resident had on glasses as he read from a bible placed on his bed. In an interview on 04/10/25 at 11:20 AM, the MDS Nurse said the purpose of the MDS was to capture every aspect of care the resident received while at the facility. She said it was an interdisciplinary process with multiple parties' inputs, but she did the data review to ensure accuracy. She said Resident #68 wore glasses and Resident #57 was bed bound with contractures and it should have been documented in their MDS and Care Plans. She said failure to complete the MDS accurately could result in inaccurate billing and an inaccurate description of the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/11/25 at 12:26 PM, the DON said Resident #57 admitted with contractures that led to a lower extremity functional impairment which had not changed since the resident admitted . She said she expected Resident #57's MDS to include her functional impairment to both legs and her diagnosis to include contractures but she does not believe it was in the resident's record. The DON said Resident # 68 wore glasses and his MDS should say he wore corrective lenses. She said failure to accurately assess a resident could place them at risk of not having their needs and worsening of health conditions. Record review of the undated facility policy titled Conducting an Accurate Resident Assessment revealed, the purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Accuracy of assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e., comprehensive, quarterly, significant change in status). 2. Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical record. 5. Information provided by the initial comprehensive assessment establishes baseline data for the ongoing assessment of resident progress.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 - Some	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** 41392 43049 Based on observation, interview, and record review the facility failed develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, which include measurable objectives and timeframes to meet resident's medical and nursing, needs for 3 of 7 residents (Residents #52, #59, #16) reviewed for comprehensive patient centered care plans. - The facility failed to develop a care plan that addressed Resident #52's dietary interventions to address low body weight and promote weight gain. - The facility failed to ensure Resident #16 and #59's care plans documented goals and interventions for hypertension. This failure could place residents at risk of weight loss and deteriorating health. This failure could place residents at risk of unsafe blood pressures and not receiving proper care and services. Findings included: Resident #52: Record review of Resident #52's Face Sheet dated 04/09/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: high blood pressure, diabetes, kidney failure and dementia with agitation. Record review of Resident #52's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS of 02 out of 15, height of 5 feet and 6 inches and weight of 119 pounds. She had a mechanically altered diet (change of food texture such as pureed food and thickened liquids to ease swallowing). Record review of Resident #52's undated care plan revealed, no documented dietary orders or interventions. An observation on 04/08/25 at 09:15 AM revealed, Resident #52 in bed under her sheets with fall mats on the floor. The resident was in no immediate distress, she was confused, frail, and skinny. In an interview on 04/10/25 at 11:20 AM, the MDS Nurse said she was responsible resident care plans, but the information was an interdisciplinary process. She said care plans should address all the resident's diagnoses and failures, fail to do so could lead to staff not knowing how to provide care for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 - Some	In an interview on 04/11/25 at 07:55 PM, the Dietician said she was following Resident #52 because the resident was under weight for her age. She said the resident responded well to the interventions in place and was gaining weight. In an interview of 04/11/25 at 12:15 PM, the MDS Nurse said if a resident was under weight and received interventions to gain weight the resident should have a dietary plan under the nutrition section of the comprehensive care plan. In an interview on 04/11/25 at 12:26 PM, the DON said since Resident #52 was considered underweight and received interventions to gain weight it should be noted in her care plan. She said failure to accurately assess residents could place them at risk of not having their needs met and worsening of health conditions. Record review of Resident #52's dated 03/21/25 at 04:13 PM completed by the Dietician revealed, weight gain. The resident's BMI was 19.4 and she was underweight for her age. Resident #52 had 20.2% weight gain in the last 180 days. Resident #52 was on a fortified diet (adding nutrients to food to improve its nutritional content of food) and received House Shakes (a nutritional supplement for residents with health concerns) three times daily. Record review of Resident #52's Weight Summary dated 04/09/25 revealed: 04/04/25 124.4 Lbs Standing 03/06/25 120.2 Lbs Standing 02/06/25 121.0 Lbs Standing 01/06/25 119.0 Lbs Standing 12/06/24 115.0 Lbs Standing 11/22/24 110.0 Lbs Standing 11/15/24 105.0 Lbs Standing 11/08/24 100.0 Lbs Standing 11/01/24 102.8 Lbs Standing 10/25/24 107.4 Lbs Standing 10/18/24 100.0 Lbs Standing Record review of Resident #52's Order Summary dated 04/09/25 revealed, Regular diet Mechanical Soft texture, Regular consistency, mech soft as tolerated per hospice, fortified foods at all meals start date 11/21/24. House Shake three times a day start date 12/18/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 - Some	Record review of the facility undated policy titled Weight Monitoring revealed, Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences. The care plan should address the following, to the extent possible: a. Identified causes of impaired nutritional status b. Reflect the president's personal goals and references c. Identify resident-specific interventions d. Time frame and parameters for monitoring e. Updated as needed such as when the resident's condition changes, goals are met, interventions are determined to be ineffective or new causes of nutrition-related problems are identified. f. If nutritional goals are not achieved, care planned interventions will be reevaluated for effectiveness and modified as appropriate. g. The resident and/or resident representative will be involved in the development of the care plan to ensure it is individualized and meets personal goals and preferences. Resident #59 Record review of Resident #59's face sheet dated 04/10/2025 revealed a [AGE] year-old first admitted to the facility on [DATE]. His diagnoses included stroke, and heart disease. Record review of Resident #59's quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. He had impairment to one side of upper and lower extremity. He used a wheelchair for mobility. He required partial assistance with most ADLs. Section I - Active Diagnoses included Hypertension. Record review of Resident #59's physician's orders dated 04/10/2025 revealed an order for Amlodipine 5mg one time a day related to hypertension. Record review of Resident #59's April 2025 MAR indicated he last received Amlodipine 5mg on 4/09/25 at 7:00 AM. Record review of Resident #59's undated care plan revealed hypertension, goals and interventions were not addressed. Resident #16 Record review of Resident #16's face sheet dated 04/10/2025 revealed an [AGE] year-old first admitted to the facility on [DATE] and initially admitted on [DATE]. Her diagnoses included stroke, hypertension (elevated blood pressures), and peripheral vascular disease (a slow progressive disorder of the blood vessels),. Record review of Resident #16's annual MDS dated [DATE] revealed a BIMS score of one out of 15 indicating severe impaired cognition. She was dependent on assistance from staff for most ADLs. She was always incontinent of urine and frequently incontinent of bowel. Section I - Active Diagnoses included Hypertension. Record review of Resident #16's physician orders dated 04/10/2025 revealed an order for Amlodipine 5mg one time a day related to hypertension. Carvedilol 6.25mg one tablet two times a day for hypertension. Losartan 25mg daily related to hypertension. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 - Some	Record review of Resident #16's April 2025 MAR indicted she last received Amlodipine 5mg on 04/09/25 at 9:00 AM, Carvedilol 6.25mg on 04/09/25 at 8:00 AM and Losartin 25mg on 04/09/25 at 8:00 AM. Record review of Resident #16's undated care plan revealed hypertension, goals and interventions were not addressed. Interview on 04/10/25 at 11:00 AM, the MDS nurse stated the care plan was a reference guide and provides information if the resident was at high risk or if there is anything specific to watch out for. She stated she used an MDS tool kit, the residents' diagnoses, resident medications, and every extra information to help develop the MDS and care plan. She stated she used clinicals or hospital records and mainly uses the diagnoses. She stated the MDS does trigger the care plan. She stated whatever triggered she would include in the care plan. She stated if the resident has HTN or cardiovascular disease, it would be in the care plan. She stated if a resident receives anti-hypertensives at the facility, she would need to actively check the medication list. She stated it would not be a trigger from the cause section of the MDS. She stated it was important to care plan so the staff would know to monitor BPs and to be aware of s/sx of cardiac issues. She stated she did not know why Resident #16 and #59's care plans did not address hypertension and moving forward she would need to actively update the care plans. Interview on 04/10/25 at 12:17 PM, the DON stated the purpose of the care plan was to let everyone know what type of care to provide for the resident. The DON stated she initiated the care plan with new admits, MDS nurse and nursing would be responsible for the care plan as well. She stated if a resident had a diagnosis of hypertension, it should be in the care plan. She stated Resident #16 and #59's hypertension was most likely overlooked. She stated not everyone would be aware the resident had hypertension in case a crisis happened if hypertension were not addressed in the care plan. The DON stated going forward she would need to follow up on the care plans for Resident #16 and #59. Record review of the facility undated policy titled Comprehensive Care Plan revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality Policy Explanation and Compliance Guidelines: .3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview, and record review the facility failed to ensure the resident received treatment and care in accordance with professional standards of practice, for 1 of 8 residents (Resident #67) reviewed for Quality of Care. -The facility failed to initiate the facility fall procedure after the state surveyor reported the suspect fall of Resident #67 to the DON. This failure could place residents at risk for pain and injury. Findings included: Record review of Resident #67's Face Sheet dated 04/10/25 revealed, a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses to include: muscle wasting, and unspecified lack of coordination. Record review of Resident #67's Quarterly MDS dated [DATE] revealed, intact cognition as indicated by a BIMS score of 15 out of 15, and the resident had 2 falls since the prior assessment in which she suffered no injury. Record review of Resident #67's undated Care Plan revealed, focus- resident was at high risk for falls related to impaired mobility/weakness; intervention 01/30/25 bed in lowest position and fall mat on the right side of bed. An observation and interview on 04/08/25 at 09:45 AM revealed, Resident #67 had a fall mat on the right side of her bed and the resident's bed was low to the ground. The resident sat up in her bed with her feet on the floor. Resident #67 said she thought she fell last night but did not remember if she reported it to the staff. The resident had no visible bruises or injuries and appeared to be alert and oriented. In an interview and observation on 04/08/25 at 09:48 AM, the surveyor notified the DON that Resident #67 reported she thought she fell the previous night. The DON said Resident #67 was under fall protocols, had multiple falls in the past but the resident was confused and she probably did not fall because she did not hear anything about it. The DON left the surveyor and entered Resident #67's room. In an interview on 04/10/25 at 10:21 AM, the DON said when she interviewed Resident #67 the resident said the fall might have happened in her dream, so she treated it like it did not happen. She said she did not implement the facility fall protocol, she did not treat it as an unwitnessed fall, and she did not initiate physical or neurological assessments (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 04/11/25 at 08:10 AM revealed, Resident #67 on her right side in bed. The resident was alert and oriented with no visible bruising. Resident #67 said she had falls in the past, mostly in the bathroom, and when she fell the facility checked on her. The resident appeared confused and said she did not remember falling on 04/07/25 and she did not remember notifying any staff or member of the survey team that she fell during the current week. In an interview on 04/11/25 at 12:26 PM, the DON said immediately after a fall staff are expected to initiate the facility fall procedure. Nursing staff assessed the resident for injuries and if there were no injuries the resident is transferred back into bed safely and notifications were sent to the MD, DON, and family. She said all falls should be documented in an accident/incident report and the resident's progress notes. The DON said if the fall was unwitnessed, neuro checks should be initiated immediately at set frequency to assess for altered mental status that could be associated with a head injury. She said once the surveyor notified her that Resident #67 fell , she talked to the resident who appeared confused and the resident said she did not think she fell , and she fell in her dream. The DON said she observed nothing was wrong with the resident, so she did nothing. She did not initiate neuro checks, did not do a formal assessment, and did not do an accident/incident report. The DON said she should have treated it like a fall and initiated the facility fall protocol. She said failure to take immediate action following the fall could put residents at risk for unidentified injuries, altered mental status and decreased mobility. Record review of Resident #67's Clinical Assessments revealed, no fall assessments or neuro checks were completed on 04/08/25 through 04/10/25. Record review of Resident #67's Progress notes revealed, there was no documentation of a suspected fall from 04/07/25 through 04/09/253. Record review of Resident #67's Progress note dated 04/10/25 at 11:31 AM the DON wrote Data : Notified of recent unwitnessed fall. During interview resident actually denied falling, stated I don't think I fell , I think I was dreaming. Resident denies pain, headache, dizziness at this time. Action : Assessment completed with PERRLA within baseline. PT/OT screening for safe transfer evaluation. MD/RP notified Response : Will continue to monitor. Record review of the undated facility policy titled Fall Prevention Program revealed, A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere. 9. When any resident experiences a fall, the facility will: a. Assess the resident. b. Complete a post-fall assessment. c. Complete an incident report. d. Notify physician and family. e. Review the resident's care plan and update as indicated. f. Document all assessments and actions. g. Obtain witness statements in the case of injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the undated facility policy titled Incidents and Accidents revealed, 5. The following incidents/accidents require an incident/accident report but are not limited to . oFalls, o Medication or treatment errors oObserved accidents/incidents. 6. In the event of an incident or accident, immediate assistance will be provided, or securement of the area will be initiated unless it places one at risk of harm. 7. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions. 10. In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet. Abnormal findings will be reported to the practitioner. 12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. 13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications, and orders obtained or follow-up interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview and record review, the facility failed to provide necessary treatment and services to promote Based on observation, interview and record review, the facility failed to provide necessary treatment and services to promote healing and prevent worsening pressure sores for 1 of 8 resident (Resident #57) reviewed for pressure sores. - The facility failed to provide repositioning and pillows/wedges to prevent Resident #57's development of a stage 2 pressure ulcer, (an area of damage to the skin or underlying tissue that occurs when continuous pressure is placed on a particular part of the body that has skin loss to where the fat under the skin is visible but not bone, tendon or muscle), This failure could place resident at risk of development of new pressure sores, worsening of current sores, pain, suffering and infection. Finding Included: Record review of Resident #57's Face Sheet dated 04/09/25 revealed, an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses which included: muscle wasting, muscle weakness, lack of coordination, depression, and other reduced mobility. Record review of Resident #57's Admission MDS dated [DATE] revealed, resident was rarely/never understood, rarely/never understood others, had severely impaired vision. An interview for mental status was not conducted, resident had a short- & long-term memory problem, had no assessable memory/recall ability, had moderately impaired cognitive skills for daily decision making, and had an acute onset mental status change as indicated by inattention, disorganized thinking, and altered level of consciousness. Prior to admission Resident #57 was dependent for self-care, indoor mobility, and functional cognition. The resident's functional abilities such as roll left to right, sit to lying sit to stand and transfers could not be assessed due to her medical condition or a safety concern. Resident #57 was always incontinence of both bladder and bowel, was at risk of developing pressure ulcers and had no current or healed pressure ulcers and had moisture associated skin damage. Record review of Resident #57's Quarterly MDS dated [DATE] revealed, severely impaired cognition as indicated by a BIMS score of 00 out of 00, rarely/never understood others, rare/never makes self-understood, highly impaired signs and symptoms of delirium(a state of confusion due to medical conditions) which included inattention and altered level of consciousness. Resident #57 was unable to answer questions about social isolation, she was dependent on staff for all aspects of self-care such as: eating, oral hygiene, toileting, upper/lower body dressing, personal hygiene. Resident #57's was dependent on staff to roll from her back to the left and right side, and she could not be assessed for her ability to move from sit to lying, sit to stand, transfer herself or walk due to her medical conditions or safety concern, and she was always incontinent of both bladder and bowel. Resident #57 had a risk of developing pressure ulcers/injuries, and she had 1 stage 3 pressure ulcer. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0686 Level of Harm - Actual harm Residents Affected - Few	A wound care observation on 04/09/25 at 10:30 AM with the Wound Care Nurse revealed, Resident #57 lying on her left side. Both of the resident's knees were contracted and she had a pillow between her knees, bilateral moon boots and the Wound Care Nurse placed a wedge behind the resident's back. , Scars from old and present pressure ulcer were observed on the sacrum(triangular-shaped bone connected to the hip) and coccyx. There was an open area to the coccyx that was pink in the center with white edges that was approximately 1 inch round with no visible drainage. The Wound care nurse said the resident was usually confused and yelled often and Resident #57 had not been in the facility long before she developed the pressure ulcer to her sacrum. She said the facility tried to prevent the wound through nutrition, but it was an unavoidable wound, and the resident had a history of old pressure ulcers. In an interview on 04/10/25 at 09:32 AM, LVN B said when a resident nurse admits to the facility the admitting nurse completes a head-to-toe assessment on the resident identifying any wounds, bruises, or areas of concern. She said LVNs are not able to stage wounds, so the Wound Care Nurse completes a follow up assessment, identifying any new area of concerns and clarifying any areas identified in the admitting assessment. LVN B said she was Resident #57's admitting nurse in December of 2024 and when the resident arrived, she was bedbound, lying on her left side with bilateral (both sides) contractures to her lower extremity. She said on admission she observed redness to Resident #57's coccyx which she documented as redness to bottom but there were no other bruises/injuries or any scars indicating healed pressure ulcer. LVN B said she should have specifically documented where the redness was and if the area was blanchable (a wound that appears red but becomes pale when pressure is applied and returns to the original color when released indicating healthy blood flow to the area) or non-blanchable (a wound that shows not change color indicating signs of tissue damage). She said residents who are bed bound can develop pressure ulcers from being in a position for too long or being wet so measures like repositioning(turning), and the use of pillows and/or wedges are initiated upon admission to prevent the development of pressure ulcers. LVN B said based on the information she documented, from her review of the resident's chart, she could not determine if pillows/wedges were in place for Resident #57 or how often she was repositioned from her admission in December of 2024 to her development of a stage 2 pressure ulcer in January of 2025. LVN B said failure to implement measure to prevent pressure ulcers placed residents at risk of developing or worsening of pressure ulcers and pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/10/25 at 09:55 AM, the Wound Care Nurse said upon admission, the admitting nurse completed an admission screening that involved a head-to-toe assessment of the resident and documented it in the resident's chart. The Wound Care Nurse said while the admitting nurse can document what she observes on the resident skin, LVNs cannot stage wounds. She said after the resident's initial assessment, she was responsible for completing an initial skin assessment and weekly skin assessments going forward. The Wound Care Nurse said she reviewed the admitting screener prior to her skin assessment and normally addressed any discrepancies between her assessment and that of the admission nurse. She said when Resident #57 admitted to the facility in December of 2024 she had contractures, but her skin was intact. The Wound Care Nurse said bed bound residents like Resident #57 should have interventions such as diligent positioning, pillows and padding as interventions immediately upon admission to prevent the development of pressure ulcers. She said bed bound residents with contractures could develop a stage II or III pressure ulcer in as little as 2 hours with no previous signs or areas of concerns. After reviewing the resident's chart, the Wound Care Nurse said she did not know why LVN B stated Resident #57 had redness to her buttock upon admission, she did not remember if she clarified the redness to the bottom LVN B documented in the resident's admission screener, but she should have and she could not determine if the resident had positioning pillows or if she was repositioned frequently after admission. The wound care nurse said Resident #57 developed a stage 2 pressure ulcer in the facility. In an interview on 04/10/25 at 10:21 AM, the DON said upon admission residents are assessed head to toe and all concerns should be documented. She said the facility had standard orders and she expected positioning pillows in place and documented in the progress notes for bed bound residents or those with contractures. The DON said the standard of care for a bed bound resident included re-positioning, and an order should be entered to ensure the resident is rolled left-to-right at minimum every 2 hours. She said bed bound residents could go from no areas of concern to a stage II pressure in a week, so repositioning was important. The DON said failure to reposition a bed bound resident placed them at risk for discomfort, skin breakdown and opening of the skin. The DON said she expected more details in Resident #57's admission assessment of buttock with redness and the Wound Care Nurse should have followed up on the area of concern identified by the admitting nurse. She said the follow up should have been documented in Resident #57's chart and she did not see any documentation in the resident's chart to show that the Wound Care Nurse followed up on the LVN B's initial assessment of Resident #57. She said upon Resident #57's admission the admitting nurse should have entered order of some sort preferably a positioning order that included how the resident should have been positioned and how often. The DON said based on the Resident #57's record she could determine if she had positioning pillows or how often she was repositioned from admission up to the development of the stage 2 pressure ulcer. The DON said any turning or repositioning is charted in the resident's chart with the bed mobility, roll left-right task. In an interview on 04/11/25 at 08:42 AM, the Wound Care Nurse said the wound care physician did not see all residents and he did not see Stage 2 pressure ulcers. She said Resident #57's coccyx ulcer just changed to a stage 3, so she was not followed by a wound care doctor because she did not see a need for him to. Record review of Resident #57's undated Care Plan revealed, the following focus areas: *12/12/24: limited physical mobility; intervention- observe for signs and symptoms of pain/discomfort with mobility and intervene, as necessary. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0686 Level of Harm - Actual harm Residents Affected - Few	*01/13/25- stage 3 pressure ulcer on coccyx (tailbone); intervention- turn and reposition per facility protocol and as needed. Focus *02/11/25- impaired to skin integrity of right foot, blisters to right food and right great toe related to edema (observed swelling from fluid buildup), fragile skin and immobility; intervention- positioning pillows, hell suspension. *02/18/25- impairment to skin for right and left knees related to abrasion, fragile skin & contracture; intervention- the resident needs pillows, skin to skin padding at all bony prominence to protect skin while in bet and turn and reposition per facility protocol and as needed. Record review of Resident #57's Order Summary Report of all orders entered since admitted d 04/10/25 revealed the following: *An order to treat the open area to the resident's coccyx on 01/13/25. *An order to place wedge between knees when laying down in bed every shift to prevent wounds entered on 03/03/25. Further review there were no orders for repositioning, turning, positioning pillows or wedges prior to 01/13/25. Record review of Resident #57's Admit Screener dated 12/09/24 at 05:00 PM completed by LVN B revealed, Resident #57's skin color was normal. She had a sore with discoloration to upper mid back and buttock with redness. Record review of Resident #57's Progress Note completed by the Wound Care Nurse and dated 12/10/24 at 07:45 AM revealed, on admission the resident had bruising over her hands and a small abrasion on her upper mid back. Record review of Resident #57's Skin Observation dated 12/13/24 at 07:45 AM completed by the Wound Care Nurse revealed, the resident an existing bruise and an existing abrasion on her upper back. The scattered bruising to both of her hands, a small abrasion upper to mid back and had no other skin concerns. Record review of Resident #57's December 2024 TAR revealed, the only skin area treated was the resident's upper back. Record review of Resident #57's Unavoidable Skin Breakdown completed by the Wound Care Nurse dated 01/13/25 revealed, the location of the skin breakdown was the coccyx. The resident's immobility, cognitive deficits and protein/caloric malnutrition, low lab values placed her at risk for developing or delayed healing of pressure injury. Preventative interventions initiated included: heels offloaded as tolerated, lifting devices to move & turn, weekly skin checks, skin to skin padding, nutritional supplements, vitamins/minerals and Turn & reposition. Record review of Resident #57's Progress Note completed by the Wound Care Nurse on 01/14/25 at 09:41 AM revealed, new stage two pressure ulcer to the coccyx, scant drainage with a pink wound bed. Treatment was initiated and supplements and additional pillows/wedges were in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #57's Skin Observation dated 01/17/25 revealed, the resident had a new pressure ulcer on her Coccyx that measured 0.7 cm X 0.5cm X 0.1 cm. 01/14/25 a new pressure ulcer, stage two located on her coccyx with scant drainage. The wound was pink, and treatment was initiated with wound dressing, supplements, and additional pillows/wedges for offloading. Record review of Resident #57's December January 2025 Documentation Survey Report revealed, the resident only had orders to roll left and right once a shift (6 AM- 6PM and 6PM to AM). Record review of Resident #57's ADL report for 12/2024 through 01/31/25 revealed, Bed Mobility occurred on: 12/09/24- 07:14 PM 12/10/24- 03:35 PM 12/11/24- 02:47 AM, 04:10 PM 12/12/24- 01:09 AM, 11:28 am 12/13/24- 05:16 AM, 05:55 AM, 08:54 PM 12/14/24- 05:21 PM 12/15/24- 05:25 AM, 09:45 AM, 11:33 PM 12/16/24- 12:40 PM 12/17/24- 03:25 AM, 02:38 PM, 10:47 PM 12/18/25- 03:12 PM, 11:16 PM 12/19/24- 10:33 AM 12/20/24- 02:12 AM, 05:07 PM, 10:23 PM 12/21/24- 02:18 PM 12/22/24- 02:26 AM, 02:20 PM 12/23/24- 02:29 AM, 04:02 PM 12/24/24- 01:41 AM, 02:38 PM 12/25/24- 01:55 AM, 09:51 AM, 08:36 PM 12/26/24- 11:59 PM 12/27/24- 02:29 11:49 PM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0686 Level of Harm - Actual harm Residents Affected - Few	12/28/24- 09:38 AM, 09:24 PM 12/29/24- 10:41 AM, 10:22 PM 12/30/24- 03:57 PM 12/31/24- 02:08 AM, 04:13 PM, 09:30 PM 01/01/25- 01:20 PM, 10:22 PM 01/02/25- 07:48 PM 01/03/25- 07:48 PM 01/04/25- 01:57 AM, 10:19 AM, 10:46 PM 01/05/25- 10:26 AM 01/06/25- 12:21 AM, 04:12 PM, 10:37 PM 01/07/25- 12:57 PM, 10:27 PM 01/08/25- 11:22 AM 01/09/25- 02:21 AM, 10:35 PM 01/10/25- 01:05 AM, 10:00 PM 01/11/25- 09:51 AM, 10:10 PM 01/12/25- 05:25 PM, 09:08 PM 01/13/25- 12:27 PM, 11:29 PM 01/14/25- 02:11 PM, 11:43 PM Record review of the facility's undated Turning and Repositioning policy revealed, the facility's policy to implement turning and repositioning as part of their systematic approach to pressure injury prevention and management. All residents at risk of, or with existing pressure injuries, will be turned and repositioned, unless it is contraindicated due to a medical condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 8 residents (Resident #42) reviewed for accidents and supervision. -The facility failed to provide adequate supervision to prevent, a bruise, as a result of an injury of unknown origin to Resident #42s sternum (the long flat bone located in the center of the chest). These failures could place residents at risk of minor and major injuries. Findings included: Record review of Resident #42's face sheet, dated 04/11/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #42 had diagnoses which included: type 2 diabetes, paralysis affecting the right side, history of falling, muscle weakness, difficulty walking and high blood pressure. Record review of Resident #42's Annual MDS, dated [DATE], revealed moderately impaired cognition as indicated by a BIMS score of 08 out of 15. Resident #42 had no history of falls. Record review of Resident #42's, undated, Care Plan revealed focus- potential impairment to skin, related falls due to weakness. On 03/24/25 hematoma (a collection of blood outside blood vessels caused by injury or trauma) to the back of the head due to falls. On 03/29/25 swelling bruise to pinky ginger when pinched in the door hinge; intervention- follow facility protocols for treatment of injury. Focus- blood thinning therapy; intervention- take precautions to avoid falls. Record review of Resident #42's Progress Notes from 03/10/25 to 04/08/25 revealed, 03/24/25- resident had a fall and had a bruise and bump on top of her scalp. She complained of pain in her head and neck. Resident #42 was sent out to the ER . There was no mention of bruising to the resident's neck or chest. Record review of Resident #42's electronic record revealed, the resident had skin assessments on: 03/24/25, 03/31/25 and 04/07/25 . Record review of Resident #42's Skin Assessment, completed by the Wound Care Nurse, on 03/24/25, revealed the resident's skin was intact. There were no other comments. Record review of Resident #42's Skin Assessment, completed by the Wound Care Nurse, on 03/31/25, revealed the resident's skin was intact. She had scattered bruising on both hands, no new skin concern. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #42's Skin Assessment completed by the Wound Care Nurse, on 04/07/25, revealed, the resident's skin was intact. She had scattered bruising on both hands, no new skin concern. An observation on 04/08/25 at 09:43 AM revealed Resident #42 was in bed well groomed, in no immediate distress, watching TV. She had scabs on her face and a dark purple bruise with a red edge on her sternum. The resident said she did not know how she got the bruise to her sternum, and nothing happened, but she said the scabs on her face were from picking. Resident #42 did not report pain associated to the bruise, said she had no other bruises and she felt safe in the facility. In an interview on 04/10/25 at 01:25 PM, LVN D said Resident #42's bruise on her chest was there for a while but it occurred when she was not working. She said she thought the bruise was as a result of a fall, but after she reviewed the resident's accident/incident reports she said there was no documentation of Resident #42 having a bruise on her chest. LVN D said the Wound Care Nurse should follow Resident #42 since there were accident/incident reports and the resident had not complained of any pain associated to the bruise. An observation and interview on 04/11/25 at 08:17 AM revealed Resident #42 in bed with a dark blue bruise on her upper sternum with 4 lines going out from the center. She said she did not know how she got the bruise; she denied falling and said maybe she rubbed it with her hand. Resident #42 said the nurse and the DON looked at it on 04/08/25 and were monitoring it daily. In an interview on 04/11/25 at 08:42 AM, the Wound Care Nurse said bruises start off dark purple, then changed to light purple then brown to tan as they healed. She said Resident had a fall in March left her bruised all the way down the side of her chest. The Wound Care Nurse said she did not know about a bruise on the resident's chest but Resident #42 did have a wound on her neck. She said the wound on the sternum was probably followed as a wound on her neck and failure to identify an injury could place the resident at risk of developing a hematoma or nodule (a raised lump that forms when blood pulls under the skin due to an injured blood vessel.) The Wound Care Nurse said she recently assessed Resident #42 and she did not have a nodule. In an interview on 04/11/25 at 12:26 PM, the DON said bruises started as red purple then changed to yellow and then green as they healed depending on the site of the body that was injured. She said Resident #42 had a bruise on her upper sternum that was purple, and it was present on the resident since 04/01/25. The DON said nursing staff were expected to document on a new bruise and continue to document on it daily until it resolved, and the Wound Care Nurse should have documented it on her weekly assessment. The DON said she reviewed Resident #42's chart and there was no documentation of the bruise on the resident's sternum. She said after investigation she believed the failure in documentation was due to the resident's past fall that the staff attributed the bruise to. The DON said based on the documentation in Resident #42's chart it could not be determined when and how the bruise occurred. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's, undated, policy titled Incidents and Accidents revealed, .5. The following incidents/accidents require an incident/accident report but are not limited to . observed accidents/incidents, self-inflected injuries, and unobserved injuries. 6. In the event of an incident or accident, immediate assistance will be provided, or securement of the area will be initiated unless it places one at risk of harm. 7. Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions. 10. In the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet. Abnormal findings will be reported to the practitioner. 12. The nurse will enter the incident/accident information into the appropriate form/system within 24 hours of occurrence and will document all pertinent information. 13. Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications, and orders obtained or follow-up interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43049 Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assured the accurate acquiring, receiving, dispensing and administrating of all drugs and biologicals, to meet the needs of each resident for 1 of 1 Med Rooms (Station 1 Med Room) reviewed for pharmacy services. -The facility failed to ensure the Station 1 Medication Room did not contain expired oral Vancomycin (an antibiotic) for Resident #54 and Resident #200. This failure could place residents at risk of not receiving the therapeutic benefit of medications and/or adverse reactions to medications. Findings Include: In observation and interview on 04/09/25 at 10:35 AM, inventory of the Station 1 Med Room with LVN E revealed - An open and in-use bottle of Vancomycin Oral solution for Resident #200 labeled Do Not Use After: 04/07/25 in the refrigerator. - A sealed bottle of Vancomycin Oral Solution for Resident #54 labeled Do Not Use After: 04/07/25 in the refrigerator. LVN E said nurses checked the Med Room daily as used for expired medications. He said the Vancomycin solutions were expired, and they should have been pulled from the refrigerator. He said both Resident #54 and Resident #200 were no longer in the facility and their medications should have been pulled immediately after their discharge . LVN E said when medication were expired there were changes in the chemical structure which made it less effective, or it could become spoiled. He said if residents were administered expired medication, they could experience upset stomach or side effects . In an interview on 04/09/25 at 11:35 AM, the DON said nurses were expected to inspect the med rooms daily to ensure they were clean, orderly, all medications were labeled appropriately, had visible expiration dates, and were not expired. She said when a resident discharged all mediations should be pulled from the med carts and med rooms by the discharging nurse and all expired medications should be removed from the fridge daily as used by all nursing staff. The DON said, when medications expired, they could lose efficacy and use could place residents at risk of upset stomach, side effects or not receiving the therapeutic effect of their medications which could result in worsening of health conditions. Record review of the facility policy titled Storage of Medications revised 11/2020 revealed, 4- discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Medication Storage in the facility revised 08/2014 revealed, G- all expired medications will be removed from the active supply and destroyed in the facility regardless of the amount remaining. The medication will be destroyed in the usual manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41392 Based on observations, interviews, and record reviews the facility failed to ensure residents were free of significant medication error for two of seven residents (Resident #59 and #16) reviewed for significant medication errors. -The facility failed to ensure that MA B did not administer anti-hypertensive medications to Resident #59 and #16 based on BPs and pulse results obtained 1.5 hours prior to administration. This failure places residents at risk of discomfort or jeopardizing his/her health and safety. Findings include: Record review of Resident #59's face sheet, dated 04/10/2025, revealed a [AGE] year-old who was first admitted to the facility on [DATE]. His diagnoses included stroke, swallowing disorder, one sided paralysis on one side of the body , abnormal liver function vitamin deficiency, Hyperlipidemia (a condition that causes the high levels of lipids, or fats in the blood), heart disease, muscle weakness, and unsteady on feet. Record review of Resident #59's quarterly MDS, dated [DATE], revealed a BIMS score of 15, which indicated intact cognition. He had impairment to one side of upper and lower extremity. He used a wheelchair for mobility. He required partial assistance with most ADLs. Section I - Active Diagnoses included Hypertension. Record review of Resident #59's physician's orders, dated 04/10/2025, revealed an order for Amlodipine 5mg one time a day related to hypertension, hold for SBP<110 (the top number of the BP reading, measures the pressure in your arteries when the heart beats and pumps out blood), DBP<55(the bottom number of the BP reading, measures the pressure in the arteries when the heart is resting between beats), HR<55. Order start date was 09/19/24. Record review of Resident #59's April 2025 MAR revealed on 4/09/25, MA B documented administration of Amlodipine 5mg at 9:00 AM. The documented BP was 179/92 and pulse 73. Record review of Resident #59's, undated, BP summary revealed on 4/09/25 at 6:00 AM, BP was 179/62, in a lying position, using the left arm and recorded by MA B. Record review of Resident #59's, undated, pulse summary revealed on 4/09/25 at 6:00 AM, pulse was 72 bmp (beats per minute), regular and recorded by MA B. Observation on 04/09/25 at 7:35 AM of Resident #59's 8:00 AM medication pass revealed MA B administered Amlodipine 5mg oral tablet. MA B did not check Resident #59's BP and pulse prior to administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #16's face sheet, dated 04/10/2025, revealed an [AGE] year-old who was first to the facility on [DATE] and initially admitted on [DATE]. Her diagnoses included stroke, malnutrition, dementia, hypertension (elevated blood pressures), peripheral vascular disease (a slow progressive disorder of the blood vessels), Hyperlipidemia - a condition that causes the high levels of lipids, or fats in the blood), hypothyroidism (underactive thyroid gland) and adult failure to thrive (a gradual decline in health and functional abilities). Record review of Resident #16's annual MDS, dated [DATE], revealed a BIMS score of one out of 15, which indicated severe impaired cognition. She was dependent on assistance from staff for most ADLs. She was always incontinent of urine and frequently incontinent of bowel. Section I - Active Diagnoses included Hypertension. Record review of Resident #16's physician orders, dated 04/10/2025, revealed an order for Amlodipine 5mg one time a day related to hypertension, hold for SBP<110, DBP<60, HR<60. Order start date was 10/08/24. Carvedilol 6.25mg one tablet two times a day for hypertension. Order start date was 12/31/24. Losartan 25mg daily related to hypertension, hold for SBP<110, DBP<60, HR<60. Record review of Resident #16's April 2025 MAR revealed on 4/09/25, MA B documented administration of Amlodipine 5mg at 9:00 AM. The documented BP was 189/92 and pulse 92. Losartan 25mg was documented as given at 8:00 AM. The documented BP was 189/92 and pulse 92. Carvedilol 6.25 mg was documented as given at 8:00 AM. The documented BP was 189/92 and pulse 92. Record review of Resident #16's, undated, BP summary revealed on 4/09/25 at 5:57 AM, BP was 189/62, in a lying position, using the left arm and recorded by MA B. Record review of Resident #16's, undated pulse summary revealed on 4/09/25 at 5:57 AM, pulse was 92 bpm regular and recorded by MA B. Observation on 04/09/25 at 7:45 AM of Resident #16's 8:00 AM medication pass, MA B administered Losartan 25mg oral tablet and Carvedilol 6.25mg oral tablet. MA B did not check BP and pulse prior to administration. Interview on 04/09/25 at 11:20 AM, MA B stated she checked Resident #59 and Resident #16's BPs and pulse at 6:00 AM when she started her shift then she passed medications later. , MA B stated a blood pressure medication given one to 2 hours after checking the blood pressure could affect the resident, she guessed and she should have checked the blood pressures just before giving the medications. She did not say how it could affect the residents. MA B stated Resident #16's BPs run high all the time. MA Bstated she did not think using BP results from 1-2 hours prior to administration of a BP medication would be inaccurate Interview on 04/09/25 at 11:35 AM, the DON stated the expectation was the BPs should be checked right then and there when getting ready to administer that resident's BP medication. The DON stated if checked too early the BP could drop by the time the medication was actually administered, especially if it was an anti-hypertensive. The DON stated the nurses and med aides were responsible to follow the physician orders. The DON stated the nursing staff needed to be educated about not using BP results from 1-2 hours prior to administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/09/25 at 11:53 AM, MA A stated BPs checked 1-2 hours prior to administration could be inaccurate and would not want to bottom out (to an unsafe low reading) the resident's BPs. She stated this was why she would always check her own BPs and not rely on vitals signs, which included BPs checked by someone else. She stated BPs could change in 1 to 2 hours. Interview on 04/09/25 at 12:00 PM, LVN E stated the resident's BPs could drop in 1-2 hours. He stated the BP may not change much but it was best practice to check BP before giving the BP medication. He stated if someone else checked the BP, he would not know what position the resident was in when the BP was checked. He stated it would not be following the 5 rights of administering medications if the BP was checked hours before administration. Interview on 04/10/25 at 8:17 AM, MA B stated she received training on medication administration about 2 years ago when she transferred from working as a CNA on the floor to the medication aide position. Interview on 04/10/25 at 1:55 PM, the Medical Director stated BPs should be checked within 5 to 10 minutes of the medication administration. The Medical Director stated he would not recommend using results from 1 to 2 hours prior to determine administration of the BP medication because it was important if the BP was low the medication would need to be held to prevent hypotension or bradycardia (drop in heart rate). Record review of the facility's policy and procedures for Medication Administration with the copyright date of 2024, read in part: .Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters .Example guidelines for Medication Administration (unless otherwise ordered by physician), this list is not all-inclusive .Medication requiring vital signs prior to administration .Anti-Hypertensives

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43049 Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 8 residents (Resident #35) and 2 of 3 medication carts (Front Hall nursing Cart & Station 1 Med Cart) reviewed for drug labeling and storage. - The facility failed to ensure the Front Hall Nursing Cart did not contain Resident #35's open and in-use bottle of Oxcarbazepine, a seizure medication, with no open date. - The facility failed to ensure the Station 1 Med Cart did not contain Aspirin with no visible expiration date. These failures could place residents at risk of adverse medication reactions and drug diversions. Findings included: Front Hall Nursing Cart Record review of Resident #35's face sheet, dated 04/11/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #35 had diagnoses which included: type 2 diabetes, unspecified convulsions, and epilepsy (a brain disorder characterized by recurrent, unprovoked seizures). Record review of Resident #35's Quarterly MDS, dated [DATE], revealed the resident had a seizure disorder or epilepsy and had a feeding tube. Record review of Resident #35's, undated, Care Plan revealed focus- resident is on seizure medication for seizure management for epilepsy; intervention- administer anticonvulsant medications as prescribed. Record review of Resident #35's Physician Order dated 12/05/24 revealed Oxcarbazepine 300 MG/5 mL- Give 5 mL via G-tube two times a day for unspecified convulsions. In an observation on and interview 04/09/25 at 10:20 AM, inventory of the Front Hall Nurse Cart with LVN D revealed: - An open and in-use bottle of Oxcarbazepine liquid for Resident #35 with no open date and manufactures instructions to use within 7 weeks of first opening the bottle. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN E said staff were expected to check their carts daily as used for expired and inappropriately labeled medications. She said multidose containers should be labeled with the date opened to track their expiration date. LVN E said if there was no open date the medication should not be used because it was considered expired. LVN E said when medications expired, they became ineffective and if used could place residents at risk of side effects, so they were immediately pulled from use, and discarded. Station 1 Med Cart In an observation and interview on 04/09/25 at 10:55 AM, inventory of the Station 1 Med Cart with MA A revealed an open and in use bottle of Aspirin 325 mg with no visible expiration date. The expiration date was rubbed off. MA A said nursing staff was expected to check their carts daily for inappropriately labeled medications. She said if the expiration date was not legible the medication should not be used because it could be expired. MA A said when medication expired it lost its potency/efficacy and use could leave resident at risk for untreated health conditions. In an interview on 04/09/25 at 11:35 AM, the DON said nursing carts should be checked for expired and inappropriately labeled medication daily as used. She said all medications must have expiration dates and multidose containers must be dated when opened to track its expiration date. She said if a multidose container did not have an open date, it could not be used because it could be expired. The DON said when a medication expired it could lose its efficacy so it should be taken off the cart and placed in the drug disposal bin. She said if expired medications were used, they could place residents at risk for worsening of health conditions and side effects like upset stomach. Record review of the facility's, undated, policy titled Labeling of Medications and Biologicals revealed, 4. Labels for individual drug containers must include: a. The resident's name; b. The prescribing physician's name; c. The medication name (generic and/or brand name); d. The prescribed dose, strength, and quantity of the medication; e. The prescription number (if applicable); f. The date the drug was dispensed; g. Appropriate instructions and precautions (such as shake well, take with meals, do not crush, special storage instructions); h. The expiration date when applicable; i. The route of administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44591 Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for dietary services. The facility failed to ensure foods were sealed, labeled, or dated while in storage. This failure could place residents at risk of foodborne illness. Findings include: Observation of the kitchen on 4/8/2025 at 9:10 AM revealed the following: - the freezer contained an opened box, which was undated and unsealed bag of fully cooked chicken and cheese filling in a flour tortilla and an open box, which was undated, unsealed bag of breaded pork fritter patties. Observation of the kitchen on 4/9/2025 at 9:10 AM revealed the following: - the freezer contained an opened box, which was undated and unsealed bag of wavy lasagna sheet pasta. In an interview on 04/08/2025 at 9:10 AM with the Dietary Manager, she stated the importance of keeping food resealed and dated was to ensure the freshness of foods and keeping contaminants out of the food that was stored. In an interview on 04/09/2025 at 11:40 AM with the Dietary Manager, she stated the importance of keeping food resealed and dated was to ensure the freshness of foods and protecting the food from contaminants and was disappointed to find the package opened in the freezer today. In an interview 04/09/2025 at 11:45 AM with the Dietician, she stated the importance of keeping food resealed and dated was to ensure the freshness of foods and keeping contaminants out of the food that was stored. Record review of the facility's policy on Food Safety Requirements reflected .Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms Record review of the facility's policy on Date Marking for Food Safety reflected .The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675648	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conroe Health Care Center	2019 N Frazier Conroe, TX 77301

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 43049 Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public for 1 of 1 Med Rooms (Station 1 Med Room) reviewed for environment. -The facility failed to ensure the Station 1 Med Room Insulin Refrigerator did not have mildew growing in it. These deficient practices could place residents at risk of injury from exposed nails and/or infections and adverse reactions from contaminatd medications. The findings included: An observation and interview with LVN E on 04/09/25 at 10:35 AM revealed the temperature of the insulin fridge in the Station 1 Med Room was 34 degrees Fahrenheit. There was a puddle of water on the first shelve with a black powdery, flat growth that appeared to be mildew floating in it. LVN E said nursing staff were expected to check the cleanliness of the insulin fridge when they checked the temperature. He said mildew/mold in the insulin fridge could place residents at risk of contamination . In an interview on 04/09/25 at 11:35 AM, the DON said the med rooms should be organized, med refrigerators cleaned, and monitored every shift. She said the nurses and med aids should clean the fridge when there was moisture build up and failure to do so could place residents at risk of contamination of their medications leading to side effects. Record review of the facility's, undated, policy titled Environmental Services Inspection revealed, it is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis. 1. The Director of Environmental Services will perform random and/or routine inspections. 2. All opportunities will be corrected immediately by environmental services personnel.