STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the resident's physician of a significant change in the resident's physical status such as a deterioration in health and a need to alter treatment significantly such as discontinuing an existing form of treatment for 1 (CR#1) of 5 residents reviewed for physician notification.RN A failed to notify CR#1's physician- when RN A discovered CR#1's IV was dislodged on 8/5/2025 around 9:15am and needed to be discontinued.-when RN A discovered CR#1 had low blood pressure and pulse on 8/5/2025 around 9:15 a.m. and CR#1 was pronounced dead at the facility on 8/5/2025 at 10:56am. An IJ was identified on 08/06/2025 at 4:07 p.m. the IJ template was provided to the facility on [DATE] at 4:17 p.m. While the IJ was removed on 08/08/25 at 11:30 a.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not IJ due to need for ongoing monitoring.This failure could place other residents at risk of not being assessed and receiving care in a timely manner, potentially leading to injury, harm or death.Record review of CR#1's face sheet dated 8/5/2025, indicated she was a [AGE] year-old female originally admitted on [DATE] with medical diagnoses including fracture of the right humerus (upper arm), chronic obstructive pulmonary disease (a group of lung and airway diseases that restrict breathing, urinary tract infection, type 2 diabetes mellitus (high blood sugar), hyperlipidemia (high cholesterol), hypertension (high blood pressure), dementia (decline in cognitive function affecting memory, thinking and changes in personality and emotional control issues), and cognitive communication deficit. Record review of CR#1's Physician Orders dated 08/05/2025, indicated she had orders for peripheral IV inserted in the left arm with a start date of 08/04/2025 and vital signs every shift with a start date of 08/04/2025.Record review of CR#1's care plan dated 8/4/2025, indicated she had altered cardiovascular status related to Hypertension diagnosis, with interventions including administering medications as ordered and assessing and monitoring cardiovascular status and identify complications. CR#1 had an intravenous access IV for fluid therapy related to dehydration, with interventions including administering intravenous fluids as prescribed and maintaining rate of infusion as ordered and check infusion rate every one hour. Record review of CR#1's progress notes for August 2025, there were no notes related to CR#1 having abnormal vitals or IV dislodgement. On 08/04/2025 at 1:05pm, CR #1 was documented as having a temperature of 100.4 F with Tylenol 325 mg given for fever and fluids encouraged and upon reassessment CR#1's temperature was 98.6F. On 08/04/2025 at 4:48pm, it was documented that CR#1 was at risk of weight loss from diagnoses of dementia, medications and fair intake and was prescribed supplements and nutritional shakes. CR#1's intake was documented as over 50% at mealtimes. On 08/04/2025 at 10:01pm, it was documented that NP A suspected CR#1 had an infection and ordered antibiotics and IV hydration (Sodium Chloride Solution 0.9 % Use 70 ml every hour intravenously for 48 hours for dehydration). NP A ordered monitoring for CR#1 and said to not send CR#1 out. On 08/05/2025 at 11:00am, it was documented that the UM called a code at 10:25am, and the DON got the crash cart, someone else got a staff on the AED and all three initiated CPR at 10:22am with the DON and UM taking turns. Staff called 911 at 10:23am and CPR continued. 4 emergency technicians arrived at 10:29am and took over care, administered .09% normal saline and intubated CR#1. At 10:56am, CR#1 was pronounced dead by the emergency technicians.Record review of CR#1's assessments for August 2025, there were no changes in condition assessments for abnormal vitals or IV dislodging. There was a change in condition assessment dated [DATE] for elevated temperature of 100.4F, it stated CR#1 had altered level of consciousness. CR#1 had interventions which included changes in medication, IV fluids for hydration, and NP A ordered blood and urinalysis tests.Record review of CR#1's MAR for August 2025, she had the following vitals: on 8/4/2025 she had blood pressure of 129/71 and pulse of 85. and on 8/5/2025 she had a blood pressure of 118/90 and pulse of 96.Interview with CR#1's RP on 8/5/2025 at 1:52 p.m., they were concerned when on 8/4/2025 they did not see CR#1 talking or drinking water and was not awake or aware of what was going on. The RP told CR #1's nurse, who then told NP A on 8/4/2025 and NP A ordered labs and IV hydration for CR#1 on 8/4/2025. On 8/5/2025 in the morning the facility told CR#1's RP that EMT was called to the facility because CR#1 was unresponsive. In a later interview on 8/6/2025 at 4:26 p.m., the RP said she was not aware of CR#1's IV being dislodged or of her abnormal vitals, she was only told on 8/5/2025 that CR#1 was in a critical condition.Interview with RN A on 8/5/2025 at 2:44 p.m., she started a month ago and was CR#1's nurse on 8/5/2025. CR#1 had normal blood pressure earlier that morning during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to other officials (including to the State Survey Agency and adult protective services) for 1 (Residents #58) of 5 residents reviewed for reporting allegations. -The facility failed to report Resident #58's unwitnessed fall. Resident #58 had limited mobility. This deficient practice could place residents at risk for abuse, neglect, exploitation, and or mistreatment. Record review of Resident #58's face sheet captured on [DATE] revealed a [AGE] year-old female originally admitted to the facility on [DATE] and recently expired on [DATE]. Her medical diagnoses included: cognitive communication deficit (difficulty with communication muscle weakness (generalized), and displaced fracture of olecranon (break in the bony tip of the elbow at the ulna bone) process without intraarticular extension of right ulna, initial encounter for closed fracture. Record review of Resident #58's Quarterly MDS (a resident assessment tool) dated [DATE] revealed she had a BIMS score of 8, indicating moderately cognitive impairment. She was coded as unable to make herself understood and was unable to understand others with clear comprehension. She had an impairment on one side of her lower extremity and used a wheelchair. She was totally dependent on toileting, showering or bathing self, upper and lower body dressing, putting on and taking off footwear. She was also totally dependent on mobility, including transferring to and from bed, sitting to standing and lying to sitting on the side of the bed. Record review of Resident #58's care plan completed [DATE] for fall risk revealed the following dates for unwitnessed falls were: *[DATE], *[DATE], *[DATE] (fell at 7:37 AM), *[DATE] (fell on 8:41 PM) and *[DATE]. Review Resident #58's of fall risk assessment dated [DATE] reflected history of falls past 3 months. The level of consciousness/mental status indicate the resident had intermittent confusion, resident was chairbound, incontinent and required use of assistive devices (i.e. cane, wheelchair, walker). Fall risk score was 15.0, indicating risk of falls. Record review of the facility incident note date [DATE] at 10:51PM, written by LVN B reflected immediately charge nurse stepped out of Resident #58's room, she heard a sound, went straight back to resident's room observed resident by her bedside laying on her right side, with noted bleeding from her forehead, upon assessment, noted a large amount of blood flowing from resident right forehead, charge nurse immediately called for help, 911 called assessed bleeding and site wrapped. Resident #58 was transferred to a local hospital via 911 ambulance. Review of Resident #58's nurses progress notes dated [DATE] revealed resident had four stitches to her forehead. In an interview with DON on [DATE] at 2:39 PM she said Resident #58 was very confused had repeated falls, resident had history of Alzheimer's disease, had 2 falls sometimes in a day while trying to go to the restroom, on [DATE] Resident #58 had a fall with injury to her forehead with bleeding and was sent to the hospital and she had 4 stitches on her forehead. DON said Resident #58 was not able to relate to how she fell due to cognitive impairment, and she did not suspect any abuse hence she did not report it to the state. In an interview with the Administrator on [DATE] at 9:45 AM she said when resident had an unwitnessed fall especially if they hit the head, or had an injury, we send them out to a local hospital, and she would report it to the state. She stated they recently got the provider letter and look at it verbatim. She referred to provider letter. In an interview with the DON on [DATE] at 10:02am the DON said if resident could not tell you what happened and there were injuries, she would send them out. Once they get to the hospital, she follows up with the hospital to see the injury. She would report it to the Administrator, IDT and the family. If the injury is a reportable, she would report to the state. If it was a suspicious injury due to neglect or abuse, then she would report it. DON said the last training on abuse was [DATE]. Record review the facility in-services dated [DATE] revealed Abuse/neglect and Residents Right in-services were provided to staff. The facility had all staff in-serviced on abuse and neglect on [DATE], including CNA L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice the comprehensive person-centered care plan that will mean each resident's physical, mental and psychosocial needs for 1 (CR#1) of 5 residents reviewed for quality of care.-RN A failed to properly complete assessments for CR#1 when RN A found CR#1 had low blood pressure and low pulse and had her IV dislodged on 8/5/2025 around 9:15am. CR#1 was pronounced dead on 8/5/2025 at 10:56am.An IJ was identified on 08/07/2025 at 10:42am. The IJ template was provided to the facility on [DATE] at 10:49am. While the IJ was removed on 08/08/25 at 11:30am, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not IJ due to need for ongoing monitoring.This failure to accurately assess resident health status for potential interventions in a timely manner could lead to harm, injury and death.Record review of CR#1's face sheet dated 8/5/2025, she was a [AGE] year-old female originally admitted on [DATE] with medical diagnoses including fracture of the right humerus (upper arm), chronic obstructive pulmonary disease (a group of lung and airway diseases that restrict breathing, urinary tract infection, type 2 diabetes mellitus (high blood sugar), hyperlipidemia (high cholesterol), hypertension (high blood pressure), dementia (decline in cognitive function affecting memory, thinking and changes in personality and emotional control issues), and cognitive communication deficit. Record review of CR#1's Physician Orders dated 08/05/2025, she had orders for peripheral iv inserted in the left arm with a start date of 08/04/2025, vital signs every shift with a start date of 08/04/2025. Record review of CR#1's care plan dated 8/4/2025, she had altered cardiovascular status related to Hypertension diagnosis, with interventions including administering medications as ordered and assessing and monitoring cardiovascular status and identify complications. CR#1 had an intravenous access IV for fluid therapy related to dehydration, with interventions including administering intravenous fluids as prescribed and maintaining rate of infusion as ordered and check infusion rate every one hour. CR#1 had a focus area of antidepressant medication related to depression, with interventions including administering antidepressant medications as ordered by physician and monitoring and documenting side effects and effectiveness every shift and monitoring, documenting and reporting PRN adverse reactions to antidepressant therapy like changes in cognition, decline in ADL ability, falls, appetite loss and insomnia. CR#1 was also care-planned for having a stroke and taking antiplatelet medication with interventions including giving medications as ordered by the physician and monitoring and documenting side effects and effectiveness. Record review of CR#1's progress notes for August 2025, there were no notes related to CR#1 having abnormal vitals or IV dislodgement. CR#1 had documentation on 8/1/2025 at 10:14pm, her Amitriptyline for depression was awaiting delivery. On 8/2/2024 at 8:23am-8:24am, CR#1 was documented as awaiting supply from the pharmacy for Cymbalta for depression, Clopidogrel for blood thinner and Ezetimibe for cholesterol. Record review of CR#1's progress notes for August 2025, there were no notes related to CR#1 having abnormal vitals or IV dislodgement. On 08/04/2025 at 1:05pm, CR #1 was documented as having a temperature of 100.4 F with Tylenol 325 mg given for fever and fluids encouraged and upon reassessment CR#1's temperature was 98.6F. On 08/04/2025 at 4:48pm, it was documented that CR#1 was at risk of weight loss from diagnoses of dementia, medications and fair intake and was prescribed supplements and nutritional shakes. CR#1's intake was documented as over 50% at mealtimes. On 08/04/2025 at 10:01pm, it was documented that NP A suspected CR#1 had an infection and ordered antibiotics and IV hydration (Sodium Chloride Solution 0.9 % Use 70 ml every hour intravenously for 48 hours for dehydration). NP A ordered monitoring for CR#1 and said to not send CR#1 out. On 08/05/2025 at 11:00am, it was documented that the UM called a code at 10:25am, and the DON got the crash cart, someone else got a staff on the AED and all three initiated CPR at 10:22am with the DON and UM taking turns. Staff called 911 at 10:23am and CPR continued. 4 emergency technicians arrived at 10:29am and took over care, administered .09% normal saline and intubated CR#1. At 10:56am, CR#1 was pronounced dead by the emergency technicians. Record review of CR#1's MAR for August 2025, CR#1 did not get Amitriptyline Hcl 50 mg 1 tablet by mouth at bedtime for depression on 8/1/2025 at 9pm, Clopidogrel Bisulfate 75 mg 1 tablet by mouth one time a day for blood thinner on 8/2/2025 at 9:00am, Cymbalta Capsule 60 mg 1 capsule by mouth one time a day for depression on 8/2/2025 at 9am and Ezetimibe 10-10 MG 1 tablet by mouth one time a day for depression on 8/2/2025 at 9am. CR#1 had the following vitals: on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infections for 1 (Resident #65) of 2 residents observed for indwelling urinary catheters. -The facility failed to ensure CNA A provided appropriate care for Resident #65 during Foley catheter care. Resident #65's indwelling catheter was not secured to his thigh, his catheter bag was placed on the bed when it should have been emptied before incontinent care. CNA A did not open Resident #65's labia to clean and did not clean the catheter from the insertion site. This failure could place residents at risk for urinary tract infection, discomfort, skin breakdown and decreased quality of life. Record review of Resident #65's face sheet revealed 78 years- old female was admitted to the facility on [DATE]. Her diagnose were encephalopathy (any group of conditions that cause brain dysfunction characterized by confusion, pressure ulcer stage 2, urinary tract infection dementia (a decline in mental ability severe enough to interfere with daily life), and obstructive reflux uropathy (a condition in which the flow of urine is blocked) Record review of Resident #65's admission MDS dated [DATE] indication BIMS (Brief Interview for Mental Status) of 14 revealed mild cognitive impaired. Section H (Bladder and Bowel) reflected the resident was always incontinent (continent voiding). It further revealed the resident was extensive to totally dependent on staff with all ADL care, with one to two staff assist. It also revealed the resident was incontinent of bowel and continent of bladder with the use of indwelling catheter. Record review of Resident #65's care plan dated 8/2/25 revealed the resident has an indwelling foley catheter related to the obstructive reflux uropathy. Interventions: provide catheter cleaning and perineal hygiene every shift and PRN (as needed) if soiled. Record review of Resident #65's Physician Order Summary Report for the month of July 2025 reflected the following order: -Dated 07/31/25, Urethral indwelling urinary catheter 16Fr with 10cc normal saline balloon using a closed drainage system (a catheter inserted into the urinary bladder and connected to tubing that is connected to a drainage bag. The drainage of urine is total dependent on gravity. The tubing and drainage bag to collect urine must be kept below the level of the bladder). Observation on 08/07/25 at 1:53 PM, of Foley catheter care for Resident #65 by CNA A and CNA B assisting, revealed the staff washed their hands and donned PPE that consisted of a disposable gown and gloves. The staff removed the resident's Foley drainage bag which hung to gravity on the right side of bed below the resident bladder, placed the Foley drainage bag in the bed with resident, and proceeded with Foley catheter care which was not secured. CNA A did not open the labia to clean and did not cleaned the indwelling catheter from the insertion site, she left the catheter bag on the bed, with cloudy urine sediments and had 700cc yellow urine. When staff was done providing care, they placed the resident to her left side and placed the resident's Foley drainage bag below the resident's bladder on the bedrail. Interview on 08/7/25 at 2:28 PM, CNA A said she was not aware the urine bag had 700 cc of urine she would have emptied it before performing Foley care. CNA A said she had been working with the facility for 2 years n the 6a-2p shift, she did no in-service on foley incontinent care, but she had it on incontinent care. Incontinent care was 2 years ago with the previous DON and had it this morning 8/7/25. UM watched her do it and had checkoffs today. She said she should have emptied her foley first, she said this was not her hall. She said the last aide should have emptied it, but because it was not. CNA A should have emptied the bag at the start of incontinent care, and she said when someone started providing incontinent care, they do not want to disturb the bag. She placed the 700cc bag on the bed, and there was sediment. The bag should not be pulling during incontinent care, and so it should have been taped to hold it in place, and it was not there either. She should have opened the labia to clean. Interview with CNA B on 8/7/25 at 2:45 PM, she said CNA A did not open the labia. The nurse should have put a clip to secure the foley bag so that it would not pull out and Resident #65 should have received barrier cream. Interview on 08/07/25 at 4:57 PM, the DON said when providing Foley catheter care for a resident, the Foley drainage bag should not be placed on the bed because this placed the resident at risk for urinary tract infections. The DON said the facility did not have a policy on Foley catheter care and no in-services for catheter was presented.Interview on 08/07/25 at 5:04 PM, the UM said when a staff provided care for a resident with a Foley catheter, the drainage bag should not be placed on a resident's bed for infection control and because urine could backflow placing the resident at risk for urinary tract infection. The UM said the foley drainage bag should be placed on the side of the bed below the bladder when they repositioned the resident in bed and the nurses secures the foley to prevent pulling. Record review of the facility dated (Revised September

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate administration of all drugs and biologicals) to meet the needs of each resident for 2 (Resident #26 and CR#1) of 6 residents reviewed for pharmacy services. -Resident #26's physician's order for Calcium-Vitamin D Tablet 600-200 MG-UNIT was not administered as ordered on 08/06/2025. Residents #26's physician order for supplement 30 ml order date was not given as ordered on 7/6/25. Resident #26 was given 120 mls instead of 30 mls.--The facility failed to provide CR#1 with her medications following physician orders including Amitriptyline HCl Oral Tablet 50 MG one tablet by mouth at bedtime for depression with a start date of 8/1/2025, Clopidogrel Bisulfate Oral Tablet 75 MG one tablet by mouth one time a day for blood thinner with a start date of 8/2/2025, Cymbalta Oral Capsule Delayed Release Particles 60 MG one capsule by mouth one time a day for depression with a start date of 8/2/2025, Ezetimibe oral tablet 10-10mg one tablet by mouth in the evening for lower cholesterol with a start date of 8/2/2025. The deficient practice could place residents at risk of not receiving the therapeutic effects from their medications as intended by the prescribing physician order. Resident #26 Record review of Resident #26's face sheet, dated 08/06/2025 reflected Resident #26 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of edema (swelling), obesity (excess fat), and chronic respiratory failure (syndrome in which the respiratory system fails in one or both of its gas exchange functions: oxygenation and carbon dioxide elimination). Record review of Resident #26's quarterly MDS, dated [DATE], reflected Resident #26 had a BIMS score of 13, indicating no cognitive impairment. Record review of Resident #26's physician order dated 07/06/2025 reflected Calcium-Vitamin D Tablet 600-200 MG-UNIT Give 1 tablet by mouth one time a day and Supplement Pass two times a day for supplement 30 ml start order date was 01/24/2025. Record review of Resident #26's MAR order dated 08/01/2025 revealed no order for Calcium-Vitamin D Tablet 600-200 MG-UNIT Give 1 tablet by mouth one time and Supplement Pass two times a day for supplement 30 ml. During medication administration observation on 08/06/2026 at 8:01 am LVN O did not give Resident #26's Calcium-Vitamin D Tablet 600-200 MG. LVN O gave Resident #26's Supplement Pass 120 mls. During an interview with LVN O on 08/07/2026 at 1:44p.m., LVN O stated the Nurses were responsible for transcribing physician's orders to MAR and she did not see an order for Calcium-Vitamin D Tablet 600-200 MG and for giving Resident #26 supplement pass of 120 ml instead of 30ml, she said she was very sorry and would check the physician's order well. During an interview with the DON, 08/08/2025 at 11:50a.m., the DON stated she was informed on the missed Calcium-Vitamin D Tablet 600-200 MG and she research the order and found out the NP wrote the order in the TAR instead of the MAR and would notified the physician of the missed dose The DON stated it was important to not miss a dose of the Calcium-Vitamin because it needs to be a consistent treatment and we are to follow the physician orders. CR #1 Record review of CR#1's face sheet dated 8/5/2025, she was a [AGE] year-old female originally admitted on [DATE] with medical diagnoses including fracture of the right humerus (upper arm), chronic obstructive pulmonary disease (a group of lung and airway diseases that restrict breathing, urinary tract infection, type 2 diabetes mellitus (high blood sugar), hyperlipidemia (high cholesterol), hypertension (high blood pressure), dementia (decline in cognitive function affecting memory, thinking and changes in personality and emotional control issues), and cognitive communication deficit. Record review of CR#1's Physician Orders dated 08/05/2025, she had the following orders: *peripheral iv inserted in the left arm with a start date of 08/04/2025, *vital signs every shift with a start date of 08/04/2025, *Amitriptyline HCl Oral Tablet 50 MG one tablet by mouth at bedtime for depression with a start date of 8/1/2025, *Clopidogrel Bisulfate Oral Tablet 75 MG one tablet by mouth one time a day for blood thinner with a start date of 8/2/2025, *Cymbalta Oral Capsule Delayed Release Particles 60 MG one capsule by mouth one time a day for depression with a start date of 8/2/2025, and *Ezetimibe oral tablet 10-10mg one tablet by mouth in the evening for lower cholesterol with a start date of 8/2/2025. Record review of CR#1's care plan dated 8/4/2025, she had altered cardiovascular status related to Hypertension diagnosis, with interventions including administering medications as ordered and assessing and monitoring cardiovascular status and identify complications. CR#1 had an intravenous access IV for fluid therapy related to dehydration, with interventions including administering intravenous fluids as prescribed and maintaining rate of infusion as ordered and check infusion rate every one hour. CR#1 had a focus area of antidepressant medication related to depression, with interventions including administering antidepressant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675663	A. Building B. Wing	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fort Bend Healthcare Center	3010 Bamore Rd Rosenberg, TX 77471

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 - Few	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. Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility were secured and stored properly for one of three medication carts (100 Hall Nurse Medication Cart) reviewed for drug storage. - UM failed to ensure 100 hall Nurse medication cart was locked when left unattended on 08/07/2025. -There were 4 over-the-counter medications observed opened with no date in the medication cart on 08/07/2025, including 24-hour Allergy Nasal spray, Latanoprost Sol 0.005%, Geri-Tussin -Guaifenesin (expectorant), and Milk of Magnesia. These failures could place residents at risk for possible drug diversions or accidental ingestion. During observation on 8/7/25 at 1:35PM, medication cart on 100 hall was left unlocked and there was no nurse around the medication cart. At 1:45 PM UM came to the hallway stated she mistakenly left the cart open, and she thought she locked it. Further observation of the 100 Med cart revealed the following medications were not dated: 1. 24 -hour Allergy Nasal spray open with no dated 2. Latanoprost Sol 0.005% open not dated 3. Geri-Tussin -Guaifenesin -expectorant 16 FL oz (473) 4. Milk of Magnesia -16Fl oz (473ml) open not dated Interview with UM on 8/7/25 at 1:48 PM she said it supposed to have open date and it only good for 30 days after it was open. The UM said she did not realize she left the medication cart unlocked. UM said medication cart should not be left opened or unlocked to prevent confused residents taking wrong medications or any staffs assessing medication cart. Interview on 08/7/25 at 4:26 p.m., the DON said all medication carts should be locked at all times before the cart is left unattended. She said if the resident took the drug, the resident might have an adverse reaction. Medication opened should be dated to help nurses know it effectiveness, DON said most drugs are good for 30 days when opened. Record review of the facility's policy on Security of Medication Cart: Policy reviewed April 2007, had the following heading: The medication cart shall be secured during medication passes. 3. When it is not possible to park the medication cart in the doorway, the cart should be parked in the hallway against the wall with doors and drawers facing the wall. The cart must be locked before the nurse enters the resident's room. 4. Medication carts must be securely locked at all times when out of the nurse's view. 5. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room. Storage of medications revised April 2007 did not address dating medication.