STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675714	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tomball Rehab & Nursing	815 N Peach St Tomball, TX 77375

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 5 residents (Resident #1) reviewed for pharmaceutical services. The facility did not administer Resident #1's medication as prescribed. This failure placed residents at risk of experiencing worsening conditions, infection, and further decline. Findings include: Record review of Resident #1's face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included acute kidney failure, major depressive disorder, chronic pain syndrome, paraplegia, insomnia, muscle weakness, and Type 2 diabetes mellitus without complications. Review of Resident #1's Quarterly MDS dated [DATE] revealed the following:*Section C revealed a BIMS score of 15 (cognitively intact).*Section G regarding resident's Activities of Daily Living (ADL) Assistance revealed resident needs supervision and one persons assisting with bed mobility, transferring and toilet use. It also revealed resident required one-person assistance with dressing, and personal hygiene.Record review of Resident #1's physician order dated 04/02/26 reflected a prescription for Levaquin 500 mg PO at bedtime. The order was entered into the EMR by the Nurse Practitioner at 11:34 AM on 04/02/26 but was not confirmed until 12:39 AM on 04/03/26. Record review of Resident #1's Medication Administration Record (MAR) dated 04/02/26 revealed an order for Levaquin 500 mg PO, one tablet at bedtime. Documentation indicates the medication was not administered until bedtime on 04/03/26. Interview on 04/07/26 at 10:00 AM, the Nurse Practitioner (NP) reported that an order for Levaquin 500 mg PO was entered into the EMR at 11:34 AM on 04/02/26 for Resident #1. The medication was scheduled to start at 9:00 PM on 04/02/26; however, order confirmation did not occur until 12:39 AM on 04/03/26. Consequently, the initial dose was administered at 9:00 PM on 04/03/26. Interview conducted on 04/07/26 at 10:35 AM with LVN-A (the nurse responsible for receiving the physician order for Resident #1's Levaquin 500 mg PO at bedtime on 04/02/26). LVN-A stated she did not recall receiving the order from the Nurse Practitioner and was not aware that the medication required confirmation on 04/02/26. Interview conducted with the facility Director of Nursing (DON) on 04/07/26 at 11:32 AM. The DON stated that the physician order for Resident #1 should have been confirmed within two hours of being entered into the EMR. She further stated there was no justification for the delay in confirmation, which did not occur until 12:39 AM on 04/03/26. Interview conducted with the facility Administrator on 04/07/26 at 11:49 AM. The Administrator stated that when a physician's order was entered into the EMR, it was expected to be confirmed within two hours and carried out as prescribed. Record review of the facility's medication treatment administration and documentation policy dated 04/06/23 revealed it read in part, . 2.Administer the medication according to the physician order .

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure laboratory services were obtained and reported in a timely manner for 1 of 5 residents (Resident #4) reviewed for laboratory services. The facility failed to ensure prompt communication of Resident #4's stat laboratory order which delayed further medical assessment and treatment. This failure placed residents at risk of experiencing delays in clinical decision-making and treatment. Findings include: Record review of Resident #4's face sheet revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included urinary tract infection, acute kidney failure, cognitive communication deficit and delusional disorder. Record review of Resident #4's Quarterly MDS dated [DATE] revealed the following:*Section C revealed a BIMS score of 1 (severe cognitive impairment).*Section G regarding resident's Activities of Daily Living (ADL) Assistance revealed resident needs supervision and one persons assisting with bed mobility, transferring and toilet use. It also revealed resident required one-person assistance with dressing, and personal hygiene. Record review of Resident #4's care plan dated 04/07/26 revealed Resident#4 was care planned for falls. ADL Self Care Performance Deficit:Goal-Resident will remain free from falls. Approach- Residents bed will be placed in its lowest position and a fall mat will be placed next to the resident's bed. Record review for Resident #1 physician's orders for March 2026 and April 2026 revealed a STAT laboratory test was entered into the electronic medical record on 04/02/26 at 10:21 AM. Further review showed the order was not confirmed until 1:30 PM by LVN-A. Interview conducted on 04/09/26 at 10:15 AM, the NP reported that a STAT laboratory/imaging order for a KUB for Resident #4 was issued at 10:29 AM on 03/24/26. The NP stated that the order was not confirmed until 10:09 PM on 03/24/26, indicating a significant delay in processing a STAT order. In an interview conducted on 04/09/26 at 10:00 a.m. with the facility Administrator, she stated that physician orders that are ordered stat should be confirmed right away. She stated that the KUB lab for Resident#4 that was ordered on 03/24/26 at 10:29am should have been confirmed right away and not at 10:09pm. Interview conducted on 04/09/26 at 10:44 AM, LVN-A stated that she did not recall the Nurse Practitioner issuing a STAT order for Resident #4 on 03/24/26 at 10:29 AM. LVN-A further stated that she received a high volume of orders and was not always notified when orders are entered into the electronic medical record. During an interview on 04/09/26 at 2:15 PM, the facility administrator stated the delay in confirming the STAT KUB order for Resident #4 was not acceptable. Record review of the facility's policy titled STAT Laboratory Services, dated 02/13/2020, revealed the following:If the laboratory technician has not arrived within one (1) hour, the nurse is to notify the laboratory again.If the laboratory technician has not arrived within two (2) hours, the nurse is to notify the Director of Nursing (DON).If the laboratory technician has not arrived within three (3) hours, the nurse is to notify both the DON and the physician for further direction.