STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675818	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Cyfair	11001 Crescent Moon Dr Houston, TX 77064

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed the resident the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents for 1 (Resident #1) of 5 residents reviewed for resident rights.-The facility failed to ensure Resident #1's call system was within reach.This failure could place residents at risk of not receiving assistance when required or needed.The findings included:Record review of Resident #1's admission Record, dated 04/30/26, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included other cerebral infarction (ischemic stroke), weakness, type 2 diabetes mellitus without complications (high blood sugar), and unspecified symptoms and signs involving the nervous system.Record review of Resident #1's MDS Assessment, dated 04/10/26, revealed a BIMS score of 13, indicating her cognition was intact. Further review revealed resident was dependent (helper does all of the effort) with lower body dressing and required substantial/maximal assistance (helper does more than half the effort) with toileting and shower/bathe self.Record review of Resident #1's Care Plan, dated 04/06/26, revealed she had bowel incontinence r/t CVA and was unable to control urination AEB: Always incontinent.Observation and interview on 04/30/26 at 10:39 a.m., revealed Resident #1 was sitting in her wheelchair, next to her bed, with her back turned toward the entry door. The back of Resident #1's wheelchair was approximately 5-6 inches away from the footboard and she was facing her bedroom wall. Her bedside table was in front of her with her breakfast tray, and in front of the bedside table was her nightstand. Her bed was made and the call light was clipped up toward the pillow. Resident #1 said she spilled her coffee on the floor and her pants this morning, 04/30/26, approximately around 9:00 a.m.-9:30 a.m. She said the coffee was lukewarm and did not burn, hurt, or injure her. She said a CNA (could not recall name) came to her room, cleaned up the spilt coffee, and said she would tell CNA C to change her, but she never got changed and was still wet. Resident #1 said she could not reach her call light to get the help she needed because it was too far away from where she was. She extended her arms out and demonstrated how she could not reach the call light.During an interview on 04/30/26 at 11:18 a.m., CNA C said no one told her Resident #1 spilled coffee on her pants nor that the resident requested to be changed after she finished eating her breakfast. CNA C said she had not checked on the resident since showering her this morning and after the resident was retrieved by therapy staff. She said she clipped Resident #1's call light by her pillow and was not aware that she could not reach her call light. She said if a resident's call light was not within reach, something serious could be going on and they would not be able to push their button for help. During an interview on 04/30/26 at 12:20 p.m., the DON said her expectation was for all staff to answer a call light to see what the resident may need. She said staff should report to the charge nurse and that charge nurse was to let the CNA or any CNA was working the floor know what resident(s) needed. She said they always told staff, residents call lights should be within reach and for those residents who have more of a difficult time reaching it from a long-distance range, the call light should be placed on the resident, in a location of their choosing, so they can use the call light to call for assistance.During an interview on 04/30/26 at 1:16 p.m., CNA B said it was after breakfast, (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maybe around 9 a.m.-ish, that Resident #1 had her call light on. She said she helped clean up Resident #1's spilled coffee off of her bedroom floor and around her bedside table. She said she noticed her clothes were wet when she was cleaning the resident's floor and told the resident that she needed to change her. She said Resident #1 told her she wanted to finish her breakfast first. She said the resident asked her to pour her milk into her cereal which she did and told the resident that she would let her assigned CNA, (CNA C) know to go back to her room after breakfast and change her clothes. She said she never saw CNA C or told her Resident #1 needed to be changed. She said a resident's call light had to be close to them so they could be able to push it to ask for assistance when they needed help.Record review of the facility's policy, Answering the Call Light, revised March 2012, revealed .The purpose of this procedure is to respond to the resident's requests and needs.5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .