

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675894	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Park Manor of Conroe		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Grand Lake Dr 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)
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>(continued on next page)</p>

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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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide food and drink that is palatable, attractive, and at a safe and appetizing temperature for 1 of 1 kitchen reviewed for food service safety. On 09/25/25, dietary served cold grilled cheese sandwiches and tomato soup during the dinner meal service. In September and August 2025, the facility received 28 grievances to the dietary department regarding cold and overcooked food served during meals.] This failure could place residents at risk of contracting a foodborne illness and a diminished quality of life. Findings included: Record review of Resident #1's facesheet revealed an eighty-one-year-old female who was admitted to the facility on [DATE]. Her admitting diagnoses were Type 2 Diabetes, GERD, hypertension (high blood pressure), gout (a form of arthritis), and anxiety disorder. Record review of Resident #1's care plan revealed that she was on a therapeutic CCD regular diet with regular consistency. Interventions listed were to alert the NP/MD and document resident's inability to consume diet, offer supplements and alternatives if less than 50% of the meal is consumed or resident does not like the meal, and provide diet as MD order. In relation to her Type 2 Diabetes, the intervention listed was to observe compliance with diet and document any problems. Record review of Resident #1's change in condition progress note dated 9/25/25 at 1:13 p.m. electronically signed by LVN A recorded that Resident #1 had diarrhea. The NP was notified and she was prescribed 2 tablets of Imodium 2mg every 4 hours as needed. Record review of Resident #1's nutrition progress note dated 9/09/25 at 11:06 am documented that Resident #1 stopped the dietician and requested supplements and no gravy on food. Record review of the facility's dietary staffing list revealed that there were 9 employees who worked in the kitchen. During an interview on 10/09/25 at 10:18 a.m., DM A informed the surveyor that it was her third day in that role and she was trying to revamp the kitchen. The health department visited the facility's kitchen on 10/08/25 for an impromptu inspection due to a call for a foodborne outbreak at the facility and she could provide the documentation of their passing score. She stated she could tell the previous manager did not focus on checking temperatures. In an interview on 10/10/25 at 10:20 a.m. with the AD, she stated that she had worked at the facility for over 20 years. She oversaw the resident council that met every 3rd Tuesday of the month. During the last resident council meeting, she had several complaints regarding the food not being good. In an interview on 10/10/25 at 10:31 a.m. with LVN A, she stated that she had been working at the facility for 6 months. She stated that she remembered Resident #1 having diarrhea because she read it in her progress notes, but it was not reported to her because it may have happened overnight. She explained that in the past few weeks, there had been an upturn of complaints regarding the kitchen. These complaints concerned food being burnt, cold, and coming out late. In an interview on 10/10/25 at 11:03 a.m. with LVN C, he stated that he remembered Resident #1 having diarrhea on 09/25/25. He did not remember why she had it but Resident #1 often had episodes of nausea that she attributed to the food at the facility. He received complaints about the food a couple of times a week, stating that the food was not good and residents did not like it. In an interview on 10/10/25 at 12:01 p.m. with Resident #1, she stated that since she has been at the facility over the past couple of years, the food has gone from bad to worse. She stated that she had really bad acid reflux and she started experiencing increased episodes of diarrhea that led to her doctor increasing her medication dosage to provide some relief. Resident #1 stated that she constantly had to tell the kitchen staff and DM B that she did not like sausage, but they constantly placed it on her plate every morning during breakfast. She expressed that she hated sausage and seeing it on her tray made her want to throw up. Everyday her breakfast ticket said no sausage but staff would still place it on her plate because they were not reading the tickets. She also received meals covered in gravy after she listed that she did not like gravy. She stated that she had informed the ADM about her kitchen concerns and felt she did not care because the staff were contracted with a different company. In an interview on 10/10/25 at 12:42 p.m. with DM B, she stated she was the dietary manager at the facility from 06/30/25 until she was termed on 10/06/25. She stated that prior to employment, her predecessor was well liked by everyone in the facility, and it was a hard task coming behind her and she probably was not a good fit. DM B explained that she received several grievances regarding the menu and food being cold. She felt that some of the complaints she received were valid and some of the grievances came from chronic complainers who were hard to please. She explained that during her employment, there were several dietary staff members who worked in the kitchen without their food handler's certification. She explained that in her 20 years of working in dietary, she had never received so</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>(continued on next page)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident received and was provided food that accommodated resident allergies, intolerances, and preferences for 1 (Resident #1) of 5 residents reviewed for meal preferences. Resident #1 received sausage for breakfast and gravy on her food during mealtimes after she consistently requested the removal of these items from her plate. This failure could lead to a diminished quality of life. Findings included: Record review of Resident #1's facesheet revealed an eighty-one-year-old female who was admitted to the facility on [DATE]. Her admitting diagnoses were Type 2 Diabetes, GERD, hypertension (high blood pressure), gout (a form of arthritis), and anxiety disorder. Record review of Resident #1's care plan revealed that she was on a therapeutic CCD regular diet with regular consistency. Interventions listed were to alert the NP/MD and document residents' inability to consume diet, offer supplements and alternatives if less than 50% of the meal is consumed or resident does not like the meal, and provide diet as MD order. In relation to her Type 2 Diabetes, the intervention listed was to observe compliance with diet and document any problems. Record review of Resident #1's nutrition progress note dated 9/09/25 at 11:06 am documented that Resident #1 stopped the dietician and requested supplements and no gravy on food. Record review of the facility's dietary staffing list revealed that there were 9 employees who worked in the kitchen. During an interview on 10/09/25 at 10:18 a.m., DM A informed the surveyor that it was her third day in that role, and she was trying to revamp the kitchen. The health department visited the facility's kitchen on 10/08/25 for an impromptu inspection due to a call for a foodborne outbreak at the facility and she could provide the documentation of their passing score. She stated she could tell the previous manager did not focus on checking temperatures In an interview on 10/10/25 at 10:20 a.m. with the AD, she stated that she had worked at the facility for over 20 years. She oversaw the resident council that met every 3rd Tuesday of the month. During the last resident council meeting, she had several complaints regarding the food not being good. In an interview on 10/10/25 at 12:01 p.m. with Resident #1, she stated that since she has been at the facility over the past couple of years, the food has gone from bad to worse. Resident #1 stated that she constantly had to tell the kitchen staff and DM B that she did not like sausage, but they constantly placed it on her plate every morning during breakfast. She expressed that she hated sausage and seeing it on her tray made her want to throw up. Everyday her breakfast ticket said no sausage but staff would still place it on her plate because they were not reading the tickets. She also received meals covered in gravy after she listed that she did not like gravy. She stated that she had informed the ADM about her kitchen concerns and felt she did not care because the staff were contracted with a different company. In an interview on 10/10/25 at 12:42 p.m. with DM B, she stated she was the dietary manager at the facility from 06/30/25 until she was termed on 10/06/25. She stated that prior to employment, her predecessor was well liked by everyone in the facility, and it was a hard task coming behind her and she probably was not a good fit. DM B explained that she received several grievances regarding the menu and food being cold. She felt that some of the complaints she received were valid and some of the grievances came from chronic complainers who were hard to please. She explained that during her employment, there were several dietary staff members who worked in the kitchen without their food handler's certification. She explained that in her 20 years of working in dietary, she had never received so many grievances. Some of the grievances she felt were valid like the ones who came from Resident #1. She knew that Resident #1 did not like gravy on her food and staff continued to do it because they were not slowing down and reading the tickets. In an interview with the ADM on 10/10/25 at 2:16 p.m., she stated that she sat in on the Resident Council Meeting in August and she was concerned about all of the complaints she received regarding the dietary department. This prompted her to begin a QAPI and start in-services to her staff. The facility tried to coach with DM B but her attitude made her difficult to work with and receive feedback, ultimately leading to her termination. Record review of the facility's grievance and complaint log for August showed that on 8/20/25, there were 13 grievances directed towards the dietary department. Record review of the grievances for September 2025 documented 15 complaints directed towards the dietary department. Record review of the Resident Council Meeting minutes conducted on 9/16/25 at 2:00 p.m. revealed that complaints were made regarding food being served cold, overcooked, and failure by kitchen staff to follow meal preferences. Resident #1 stated that her breakfast was served cold that morning and her waffles were still frozen. Resident #1 stated that she did not want any sausage on her breakfast tray but she still received sausage on her tray every time it was</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen reviewed for kitchen compliance. 1. Dietary staff failed to ensure all dishes and silverware were properly cleaned before utilizing during meal services. 2. Dietary staff failed to properly label/date dry storage items stored inside their pantry. 3. Dietary staff failed to properly seal dry storage items inside their pantry. 4. Dietary staff failed to utilize the chlorine sanitizer test strips and accurately document the results during each shift. 5. Dietary staff failed to document dishwashing temperatures daily. This failure could place residents at risk of contracting a foodborne illness and a diminished quality of life. Findings Included: During an interview on 10/09/25 at 10:18 a.m., DM A informed the surveyor that it was her third day in that role and she was trying to revamp the kitchen. The health department visited the facility's kitchen on 10/08/25 for an impromptu inspection due to a call for a foodborne outbreak at the facility and she could provide the documentation of their passing score. She stated she could tell the previous manager did not focus on checking temperatures of the food before meal service labeling items in the kitchen. In an observation on 10/09/25 at 10:20 a.m. inside of the dry storage inside the kitchen, the following items were found not dated or incorrectly sealed: 4 bags of cornflakes (amount not specified) not dated 6 bags of rice puffs (name not specified) were on the shelf and not dated. Packaged boxes of dry food in the middle of the floor were not dated. box of condiments not dated 2 boxes of 12lb sugar packets not dated 2 62.9fl oz of caramel not dated 1lb of celery salt not dated 1lb vegetable seasoning not dated 1lb hot cereal quick grits not dated 5.75lb of mashed potatoes with vitamin c were not dated. 10lb bag of various classic durum wheat dried pasta shells. There was a hole in the bag and it was not sealed properly. The top was cut off and the bag was folded over once and sat on the shelf. 10lb bag of noodles was left out on the shelf and folded over. Not secured or packaged in a way that maintained freshness. Dated 8-20.2 10lb bags of tri color pasta were not dated on the shelf. 5 boxes of lasagna 1lb pasta boxes not dated. 2 packs 12 count hamburger buns not dated. pack of wheat bread that felt stale to the touch sat next to the buns, 13 slices of bread not dated. Crispy feel when touched. In an observation on 10/09/25 at 10:40 a.m., stacked on a rack by the sink were green and black acrylic drink mugs. Two of the mugs were dirty and sat upright with brown splatters, brown dripping liquid, and a leftover ring from a drink. The investigator smelled inside the mugs and confirmed that the brown splatters were from coffee. Another black cup had a cream-colored residue of a leftover food substance inside. On the same row of mugs, two green mugs also had leftover splatters of black coffee inside. In an observation and interview on 10/09/25 at 10:47 a.m. with TA F, he stated that he had been working there since the middle of September, but he was previously employed at the facility. He explained that his job responsibilities were to keep the dishwashing room clean, get the trays out, and wash the dishes. When the dishes came back after meal service, he would load them and run them through the dishwasher. He explained that each load of dishes got washed for about 5 minutes and all the clean dishes would be stacked and placed on trays by another kitchen staff. When asked what type of dishwasher he used, he stated that he did not know and he could not locate the type on the machine. The temperature log was hung on the wall and TA F stated that he checked the temperature every day. When asked how, he stuttered and began to look around the dishwasher. DM A walked by and he asked her how to check the dishwasher's temperature, and she asked him where the temperature gauge was, and he could not answer. DM A asked TA F where his test strips were and he stated he did not have any and she gave him a pack of chlorine sanitizer test strips and a quaternary test kit (strips used to test sanitizer solution strength) that expired on 02/01/23. TA F took one of the strips out of the quaternary test kit and attempted to test the water by dipping the strip into the water inside the dishwasher. The strip did not change colors. He grabbed another strip out of the chlorine sanitizer test strip and dipped it in the water again. He stated it's purple and walked quickly to the trashcan without sharing the results. The surveyor asked him to let her see and he replied oh. TA F grabbed another chlorine test strip out of the bottle and dipped it inside the water of the dishwasher again. It did not change color to reflect the strength of the sanitizer in the water and he asked it's supposed to change colors isn't it?. Referring to the temperature log, TA F was asked how he documented the temperature daily if he could not locate the thermometer. He responded that the lady who worked there before (DM B) would usually fill in the temperatures on the log. He said he knew that he told the surveyor that he checked and documented the water temperatures everyday but instead he would rewrite whatever</p>		