STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675901	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Health and Rehabilitation Center	1106 Golfview Richmond, TX 77469

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 - Some	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** Based on observation, interview, and record review the facility failed to ensure residents had the right to a safe, clean, comfortable, and homelike environment including but not limited to receiving treatment and supports for daily living safely for 4 of 6 resident rooms in the 100 hall (Resident #2, Resident #3, Resident #4 and Resident #5) reviewed for environment. The facility failed to ensure Resident #2, Resident #3, Resident #4 and Resident #5's rooms were thoroughly cleaned and sanitized. This deficient practice could place residents at risk of living in an unclean and unsanitary environment which could lead to a decreased quality of life.Findings included:Resident #2Record review of Resident #2's face sheet dated 2/26/26 indicated he was a [AGE] year-old male with an original admission date of 6/24/13 and readmitted to the facility on [DATE]. His diagnoses included: acute hematogenous osteomyelitis (an infection that occurs in the bone) of left ankle and foot, acquired absence of other right toe, acquired absence of other left toe, Type 2 diabetes mellitus (the body cannot use insulin correctly and sugar builds up in the blood) with diabetic neuropathy (nerve damage cause by long-term high blood sugar), muscle weakness, and cognitive communication deficit.Record review of Resident #2's most recent quarterly MDS dated [DATE] revealed he had a BIMS score of 6 which indicated cognition was severely impaired. Resident #2 had a range of motion impairment on both sides of his lower extremities and used a wheelchair for mobility. Resident #2 required substantial/maximal assistance for toileting, shower/bath, upper body dressing, lower body dressing. Resident #2 was frequently incontinent of bladder and bowel. Resident #3Record review of Resident #3's face sheet dated 2/26/26 indicated he was an [AGE] year-old male with an admission date of 1/13/26. His diagnoses included: Alzheimer's disease (a type of dementia that affects memory, thinking and behavior), acute on chronic combined systolic and diastolic heart failure, neurocognitive disorder with Lewy bodies (a brain disorder that can lead to problems with thinking, movement, behavior, and mood), and muscle weakness.Record review of Resident #3's comprehensive MDS date 1/26/26 revealed a BIMS score of 00 indicated severe cognitive impairment. The comprehensive MDS indicated Resident #3 did not have an impairment on range of motion and he used a wheelchair for mobility. Resident #3 needed substantial/maximal assistance with shower/bathe self, partial/moderate assistance with toileting, upper body dressing, lower body dressing, and personal hygiene. Resident #3 was occasionally incontinent of bladder and bowel.Observation of Resident #2 and Resident #3's restroom on 2/26/26 at 9:09 a.m. revealed a pink latex glove on the floor beside the toilet, and a toilet seat riser with the seat covered in a brown dry substance. Resident #2 and Resident #3 were not in the room.Observation of Resident room [ROOM NUMBER] and Resident #3's restroom and interview on 2/26/26 at 11:38 a.m., revealed a pink latex glove on the floor beside the toilet and the toilet seat riser with the seat covered in a brown dry substance. Both residents were in the room and this surveyor asked if housekeeping had come in to clean the room, Resident #3 stated that someone had (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: 675901	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	come in the room earlier, but he was not sure if they cleaned.Observation of Resident room [ROOM NUMBER] and Resident #3's restroom on 2/26/26 at 12:26 p.m., revealed the toilet seat riser with the seat covered in feces, the pink glove had been removed. Resident #2 and Resident #3 were not in the room. Resident #4Record review of Resident #4's face sheet dated 2/26/26 indicated he was a [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: toxic encephalopathy (brain dysfunction caused by toxic exposure), dementia (loss of memory, language, problem-solving, and other thinking abilities), Type 2 diabetes mellitus (the body cannot use insulin correctly and sugar builds up in the blood), polyneuropathy (the widespread damage of multiple peripheral nerves, causing symmetric numbness, tingling, burning pain, and muscle weakness typically starting in the feet and hands), and muscle weakness.Record review of Resident #4's most recent quarterly MDS dated [DATE] revealed a BIMS score of 13 indicating cognition was intact. The quarterly MDS indicated Resident #4 used a wheelchair for mobility. Resident #4 needed substantial/maximal assistance with toileting, shower/bathe, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. Resident #5Record review of Resident #5's face sheet dated 2/26/26 indicated he was an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included: acute gastritis (a sudden onset of inflammation of the stomach lining) with bleeding, anemia (not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissue) in chronic kidney disease, Type 2 diabetes mellitus (the body cannot use insulin correctly and sugar builds up in the blood), chronic kidney disease stage 3A, and muscle weakness.Record review of Resident #5's comprehensive MDS dated [DATE] revealed he had a BIMS score of 12 indicating cognition was moderately impaired. Resident #5's comprehensive MDS indicated he had a range of motion impairment on both sides of his lower extremities and used a wheelchair for mobility. Resident #5 needed substantial/maximal assistance with toileting, lower body dressing, and putting on/taking off footwear. Resident # 5 needed partial/moderate assistance with upper body dressing, supervision or touching assistance with shower/bathe self, personal hygiene.Observation of Resident #4 and Resident #5's room on 2/26/26 at 12:44 p.m. revealed crumbs on the floor and a white plastic spoon. In the restroom the toilet bowl had a dried brown substance and there was one pair of soiled briefs in the corner of the restroom on the floor.During an interview with a family member of Resident #5, on 2/26/26 at 12:45 p.m. she said every time she came to visit, the room was always dirty, and she would end up cleaning the room. The family member said the bed was not made and Resident #5's clothes were all over the floor. She said somedays she would come twice a day, and the room would be dirty.During an interview on 2/26/26 at 12:50 p.m. with Housekeeping Staff A, she said her responsibilities were to clean the resident's rooms and restrooms and pick up trash. Housekeeping Staff A said if a resident was discharged from the facility, she would remove the linens from the bed. Housekeeping Staff A said she was assigned part of the 400 hall and all of the 100 hall to clean. She said when she cleaned the 100 hall, she would start at the back of the hallway and move her way up the hallway. She said if a resident or family member asked to clean a room, she would stop and handle the request. Housekeeping Staff A said when trash and soiled clothing were lying around in a resident's room, it could be hazardous to the resident, and they could get an infection.During an interview with the Housekeeping Supervisor on 2/26/26 at 1:11 p.m., she said the housekeeping staff were responsible for cleaning the rooms, sanitizing tables, cleaning the toilets. She said if a resident was discharged from the facility, the housekeeping staff would clean the bed and if no residents were in the room, the housekeeping staff would open the windows to air out the room. The Housekeeping Supervisor said the housekeeping staff do not clean when food was served to the residents. The Housekeeping Supervisor said she instructed the housekeeping (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff if they saw a food cart in the hallway, they were not supposed to clean. The Housekeeping Supervisor said if residents or family members request to clean the room, then the housekeeping staff will clean as soon as possible. The Housekeeping Supervisor said there were some rooms that needed to be cleaned twice a day. The Housekeeping Supervisor said there were some residents that took off their dirty briefs and left them in the restroom. She said the CNAs should be aware of their residents and let the housekeeping staff know when a resident takes off their adult brief. She said the risk to the residents when rooms were not cleaned could be an infection control issue.During an interview with the DON on 2/26/26 at 1:36 pm, she said housekeeping were responsible for cleaning resident rooms, mopping, and wiping down the tables. The DON said CNAs and housekeeping staff had a joint responsibility to remove the trash from resident rooms. The DON said adult briefs should be bagged off. She said the housekeeping staff do not clean while food was on the hall. She said if staff knew that a resident was messy, the housekeeping staff could prioritize cleaning those rooms.Record review of the Homelike Environment policy dated October 2009 read in part . Residents are provided with a safe, clean, comfortable and homelike environment . 2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. cleanliness and order .

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F 0656 Level of Harm - Actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for one (Resident #1) of six residents reviewed for care plans.The facility failed to specify in the care plan whether Resident #1 would be a 1-person or 2-person assist for bed mobility. Resident #1 sustained a fall out of her bed on 1/6/26 when CNA A attempted to provide a 1-person assist during incontinent care. Resident #1 sustained a comminuted, mildly impacted, intra-articular fracture of the distal left femur and returned to the facility with a leg immobilizer.This failure could lead to residents not having their individual, medical, functional, and psychosocial needs identified and cause a physical or psychosocial decline in health.Findings included:Record review of Resident #1's face sheet dated 2/4/26 indicated she was a [AGE] year-old female with diagnoses of cerebral infarction (ischemic stroke caused by a blockage in brain blood vessels), displaced comminuted fracture of shaft of left femur, lack of coordination, cognitive communication deficit, reduced mobility, need for assistance with personal care, age-related osteoporosis ((a disease that causes bones to become weak and brittle), muscle weakness, other specified disorders of bone density and structure-multiple sites, and hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction affecting left non-dominant side.Record review of Resident #1's most recent comprehensive MDS dated [DATE], revealed a BIMS score of 14 which indicated cognition was intact. Further review of the comprehensive MDS under section GG-Functional Abilities indicated Resident #1 was dependent on staff for rolling left and right. The comprehensive MDS indicated Resident #1 had a fall with major injury since admission/entry or reentry or prior assessment.Record review of Resident #1's quarterly MDS dated [DATE] indicated she was dependent for toileting, shower/bathe, and rolling left and right. In the MDS under Dependent it states - helper does all of the effort. Resident does none of the effort to complete activity or, the assistance of 2 or more helpers is required for the resident to complete the activity. Further review of the Quarterly MDS indicated Resident #1 did not have any falls since admission/entry, reentry, or prior assessment.Record review of Resident #1's care plan dated 1/7/26 indicated Resident #1 had the following care areas: *an ADL self-care performance deficit r/t functional decline contracture left knee, right elbow, wrist, and fingers. The intervention under bed mobility (roll left and right, sit to lying, lying to sitting on side of bed) indicated Resident #1 required staff assistance for bed mobility.*a positioning support device HALO as enabler. Interventions included: educate resident/family on risk and benefits on 1/4 siderails; IDT to discuss all positioning support devices; monitor for reduction of use of siderails; observe the use of positioning/support devices; provide range of motion to maintain mobility and preventive skin care to maintain intact skin.*at risk for falls r/t hx falls, hypotension, generalized weakness. Interventions included: be sure the call light is within reach and encourage to use it to call for assistance as needed; bed in lowest position, educate resident, family, caregivers about safety reminders and what to do if a fall occurs; keep needed items, water, etc., in reach; occupational, physical, speech-language therapy evaluation and treatment per physician orders.Record review of the Kardex as of 1/1/26 indicated Resident #1 required staff assistance for bed mobility. Record review of Resident #1's orders indicated the following:-1/4 right side & left side/HALO to enhance bed mobility, turning and repositioning while in bed, start date 8/28/25 and an end date of 1/19/26.-monitor level of pain using 1- 10 scale, every shift, start date (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	11/4/25 and an end date of 1/19/26.-Meloxicam oral tablet 15 mg- give 1 table by mouth every 24 hours as needed for pain, start date 5/14/25 and an end date of 1/19/26.-Tylenol oral tablet 325 mg- give 2 tablet by mouth every 6 hours as needed for mild pain, start date 5/13/25 and an end date of 1/19/26.-x-ray to bilateral knees, bilateral ankles, and bilateral femur STAT for post fall, order date 1/7/26. Record review of the incident/accident report for dated January 2026, indicated Resident #1 had a fall on 1/6/26 at 2:00 PM. The incident/accident report did not indicate whether it was witnessed or unwitnessed.Record review of Resident #1's progress note dated 1/6/26 at 2:57 p.m. input by ADON A read: during bed bath resident used mobility bar to turn and misjudged the width of the bed causing her momentum to roll off the bed before staff could stop her. She landed on the floor onto her left side. Nurse assessment completed. V/S stable. She was able to [NAME] without discomfort and assisted back to bed. She states she did not hit her head. She c/o pain to left side once in bed. Medicated for discomfort.Record Review of Resident #1's progress noted dated 1/6/26 at 3:09 pm input by RN A read: patient had a witnessed fall, no head fall, patient complained of shoulder pain and patient is AOx3. X-ray has been scheduled. MD, DON, and family has been notified. Vital sign BP 137/57, P 60, T 97.3, R 20, O2 97%.Record review of Resident #1's progress note dated 1/7/26 at 10:43 am input by LVN B read: resident complains of bilateral leg, knee, and ankle pain. NP notified and has ordered STAT X-rays to bilateral ankle, bilateral knee, and bilateral femur. Writer placed call to arrange this STAT imaging order. The result of this x-ray read the bones are osteoporotic, there is no dislocation or fracture.Record review of Resident's #1 progress note dated 1/7/26 at 10:44 am input by LVN B read: resident given two Tylenol oral tablets, 325 mg for bilateral ankle, knee, and femur pain. Pain at a level 4/10. Medication administered.Record review of Resident #1's progress noted dated 1/15/26 at 9:17 a.m. input by LVN E read: family member requesting Resident #1 to send to hospital to be evaluated for leg/knee pain. Assessed resident, voice complaints 4/10 of (L) knee/leg pain, prn Tylenol was administered, tolerated well. No facial grimacing, body relaxed at this time, no distress. Spoke with NP, with on-call doctor, aware of situation, ok to send to hospital.Record review of Resident #1's hospital record revealed CT scan of lower extremity without contrast, left, dated 1/15/26 indicated a comminuted, mildly impacted, intra-articular fracture of the distal femur. Resident #1 did not require surgery but required a leg immobilizer.During an interview with Resident #1 on 2/4/26 at 12:10 p.m. she said on 1/6/26 CNA A was applying lotion on her legs before she was pushed out of the bed. Resident #1 said she did not think CNA A pushed her on purpose, she said CNA A was not following protocol. Resident #1 said before the fall, sometimes there would be 2 staff assisting her with bed baths and incontinent care, she said the number of staff assisting her would alternate between 1 staff member to 2 staff members.During an interview with CNA A, she said she finished giving Resident #1 a bed bath and proceeded to lay Resident #1 on her side so she could put on her adult brief. CNA A said Resident #1 lied on right side as she was holding onto the mobility bar. CNA A said she asked Resident #1 three times if she had a firm grasp on the mobility bar and Resident #1 told her Yes. CNA A said as soon as she put the brief under Resident #1, she rolled out of the bed. CNA A said Resident #1 landed on her left side in a seated position. CNA A said when she came around to check Resident #1, she said Resident #1 was in shock and let out a sound like ugh, Resident #1 did not say anything. CNA A said she covered Resident #1 with a sheet because she was naked and ran down the hall to call for help. CNA A said RN A, LVN C, and CNA B came back to the room. CNA A said LVN C assessed Resident #1. She said LVN C check her head, her back, and did movement with her legs. CNA A said she and RN A put her on the Hoyer pad and used the Hoyer lift to put her back in bed.During an interview with the MDS Coordinator, she said before the fall Resident #1 was a 1-person (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	assist, now she is 2-person assist. She said the care plan showed Resident #1 required staff assistance meaning she could do some of the movement herself.During an interview with the MDS Resource Coordinator A, he said when the care plan showed staff assistance for a resident, the CNAs know it should be 1-person assist. He said the care plans are designed for 1-person or 2-person assist, depending on the strength of the CNA and also depending on the type of day the resident was having. He said for example, if a resident was having a bad day, it may require 2 to 3 staff to assist the resident with care, or if the resident was having a good day, it may only require 1 staff member to assist the resident with care.During an interview with the DON and Administrator, the Administrator said when a resident has a fall, the aides are not supposed to move the resident and notify the nurse. The DON said the aide should leave the room to get assistance or turn on the call light or holler out in the fall for help but not leave the general area. The DON said when a resident had a fall and there were 2 nurses assessing the resident, the nurse that was in charge of the resident should document the assessment. The DON said when the Kardex shows staff assistance for a resident, the aides should know the resident is 1-person assist. The DON said the Kardex is charted based on what was in section GG of the MDS. The DON said there are some days a resident would need less help than other days, more is better. The DON said if an aide was not familiar with a resident, the charge nurse would give report to the aide, and the aide should know where to access the Kardex. The DON said she did not think there was a risk when the Kardex was not specific for 1-person or 2-person assist.Record review of the facility's policy titled Resident Assessment and Associated Processes, dated 04/2025 read in part . It is the policy of this facility that resident will be assessed, and the findings documented in their clinical health record. Procedure: .Comprehensive assessment: includes the completion of the MDS (Minimum Data Set) as well as the CAA (Care Area Assessment) process, followed by development and/or review of the comprehensive care plan. an accurate comprehensive assessment will be made of the resident's needs, strengths, goals, life history, and preferences, using the RAI (Resident Assessment Instrument) and will include at least the following: physical functioning and structural problem .Record review of the facility's policy titles Comprehensive Person-Centered Care Planning, dated 04/2025 read in part . it is the policy of this facility that the interdisciplinary team shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial need that are identified in the comprehensive assessment .

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F 0689 Level of Harm - 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** Based on interview and record review, the facility failed to ensure the residents environment remained as free of accident hazards as is possible and ensure each resident received adequate supervision for one (Resident #1) of six residents reviewed for accidents and hazards.The facility failed to prevent Resident #1 from having a witnessed fall on 1/6/26 while CNA A provided incontinent care. Resident #1 sustained a comminuted, mildly impacted, intra-articular fracture of the distal femur.These failures could place residents at risk for harm, pain, and injury.Findings included:Record review of Resident #1's face sheet dated 2/4/26 indicated she was a [AGE] year-old female with an initial admission date of 12/22/23 and readmitted to the facility on [DATE]. Resident #1's diagnoses were: cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain), displaced comminuted fracture of shaft of left femur, lack of coordination, cognitive communication deficit, reduced mobility, need for assistance with personal care, age-related osteoporosis (a disease that causes bones to become weak and brittle), muscle weakness, other specified disorders of bone density and structure-multiple sites, and hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction affecting left non-dominant side.Record review of Resident #1's most recent comprehensive MDS dated [DATE], revealed a BIMS score of 14 which indicated cognition was intact. Further review of the comprehensive MDS under section GG-Functional Abilities indicated Resident #1 was dependent on staff for rolling left and right. The comprehensive MDS indicated Resident #1 had a fall with major injury since admission/entry or reentry or prior assessment.Record review of the Quarterly MDS dated [DATE] under section GG-Functional Abilities indicated Resident #1 was dependent on staff for rolling left and right. Further review of the Quarterly MDS indicated Resident #1 did not have any falls since admission/entry, reentry, or prior assessment.Record review of Resident #1's care plan dated 1/7/26 indicated Resident #1 had the following care areas:*an ADL self-care performance deficit r/t functional decline contracture left knee, right elbow, wrist and fingers, colostomy. Interventions included: resident request not to have a male help her with ADLs; occupational, physical, speech-language therapy evaluation and treatment per physician orders; toilet use- resident requires staff assistance for colostomy management and incontinent care, resident prefer to be double briefed; transfers- resident requires 2 staff assistance for transfers with Hoyer lift; bed mobility (roll left and right, sit to lying, lying to sitting on side of bed)-resident requires staff assistance for bed mobility.*a positioning support device HALO as enabler. Interventions included: educate resident/family on risk and benefits on 1/4 siderails; IDT to discuss all positioning support devices; monitor for reduction of use of siderails; observe the use of positioning/support devices; provide range of motion to maintain mobility and preventive skin care to maintain intact skin.*at risk for falls r/t hx falls, hypotension, generalized weakness. Interventions included: be sure the call light is within reach and encourage to use it to call for assistance as needed; bed in lowest position, educate resident, family, caregivers about safety reminders and what to do if a fall occurs; keep needed items, water, etc., in reach; occupational, physical, speech-language therapy evaluation and treatment per physician orders. Record review of the incident/accident report for dated January 2026, indicated Resident #1 had a fall on 1/6/26 at 2:00 PM. The incident/accident report did not indicate whether it was witnessed or unwitnessed.Resident #1's progress note dated 1/6/26 at 2:57 pm input by ADON read: during bed bath resident used mobility bar to turn and misjudged the width of the bed causing her momentum to roll off the bed before staff could stop her. She landed on the floor onto her left side. Nurse assessment completed. V/S stable. She was able to [NAME] without (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	discomfort and assisted back to bed. She states she did not hit her head. She c/o pain to left side once in bed. Medicated for discomfort.Resident #1's progress noted dated 1/6/26 at 3:09 pm input by RN A read: patient had a witnessed fall, no head fall, patient complained of shoulder pain and patient is AOx3. X-ray has been scheduled. MD, DON, and family has been notified. Vital signs BP 137/57, P 60, T 97.3, R 20, O2 97%.Resident #1's progress note dated 1/7/26 at 10:43 am input by LVN B read: resident complains of bilateral leg, knee, and ankle pain. NP notified and has ordered STAT X-rays to bilateral ankle, bilateral knee, and bilateral femur. Writer placed call to arrange this STAT imaging order.Resident's #1 progress noted dated 1/7/26 at 10:44 am input by LVN B read: resident given two Tylenol oral tablets, 325 mg for bilateral ankle, knee, and femur pain. Pain at a level 4/10. Medication administered.Record review of Resident #1's progress noted dated 1/15/26 at 9:17 a.m. input by LVN E read: family member requesting Resident #1 to send to hospital to be evaluated for leg/knee pain. Assessed resident, voice complaints 4/10 of (L) knee/leg pain, prn Tylenol was administered, tolerated well. No facial grimacing, body relaxed at this time, no distress. Spoke with NP, with on-call doctor, aware of situation, ok to send to hospital.Record review of Resident #1's electronic health record revealed x-ray results of the left shoulder dated 1/6/26 indicated no evidence of fracture, dislocation, or other acute osseous abnormality.Record review of Resident #1's electronic health record revealed x-ray results of the left femur, right femur, left knee, right knee, left ankle, and right ankle dated 1/7/26 and indicated the following: left and right femur-bones are osteoporotic, no dislocation or fracture; left knee-moderate knee osteoarthritis is present, no acute dislocation or fracture, medial collateral ligamentous calcifications are visualized; right knee-moderate to severe knee osteoarthritis is present, no acute dislocation or fracture; left and right ankle-no dislocation or fracture, bones are osteoporotic.Record review of Resident #1's hospital record revealed CT scan of lower extremity without contrast, left, dated 1/15/26 indicated a comminuted, mildly impacted, intra-articular fracture of the distal femur.During an interview with Resident #1 on 2/4/26 at 12:10 PM, she said CNA A was applying lotion on her legs before she was pushed out of the bed. Resident #1 said she did not think CNA A pushed her on purpose, she said CNA A was not following protocol. Resident #1 said she landed on her left side, she said she was shocked when she fell. Resident #1 said she was not assessed on the floor. Resident #1 said an x-ray was done of her left leg and she was not told of the results. Resident #1 said when she was at the hospital, she had a CT scan, and the results showed her femur was cracked. She said she met with the orthopedic surgeon, but at that time surgery was not recommended. She said the orthopedic surgeon put on an immobilizer cast to her left leg. Resident #1 said there needed to be 2 people when turning her. Resident #1 said she complained for 3 days of left leg pain. Resident #1 said before the fall, sometimes there would be 2 staff assisting her with bed baths and incontinent care, she said the number of staff assisting her would alternate between 1 staff member to 2 staff members.During an interview with the family member on 2/4 at 10:44 am, she said no one informed her of the fall for Resident #1. The family member said she asked the facility to take Resident #1 to the hospital because she was in pain. The family member said Resident #1 went to the hospital on January 15th, 2026. She said Resident #1 got a CT scan and the scan showed a fracture to her left femur.During an interview with CNA A on 2/4/26 at 12:40 PM, she said she finished giving Resident #1 a bed bath and proceeded to lay Resident #1 on her side so she could put on her adult brief. CNA A said Resident #1 laid on her right side as she was holding onto the mobility bar. CNA A said she asked Resident #1 three times if she had a firm grasp on the mobility bar and Resident #1 told her yes. CNA A said as soon as she put the brief under Resident #1, she rolled off the bed. CNA A said Resident #1 landed on her left side in a seated position. CNA (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675901	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Cambridge Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1106 Golfview Richmond, TX 77469	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A said when she came around to check Resident #1, she said Resident #1 was in shock and let out a sound like ugh, Resident #1 did not say anything. CNA A said she covered Resident #1 with a sheet because she was naked and ran down the hall to call for help. CNA A said RN A, LVN C, and CNA B came back to the room. CNA A said LVN C assessed Resident #1. She said LVN C checked her head, her back, and did movement with her legs. CNA A said she and RN A put her on the Hoyer pad and used the Hoyer lift to put her back in bed.During an interview with LVN C on 2/5/26 at 10:23 AM, she said on 1/6/26 when she came to Resident #1's room, Resident #1 was semi on her back on her left side, and her legs were extended out. LVN C asked Resident #1 if she was in pain, Resident #1 told her no. LVN C said she did ROM on both arms and both legs, she checked her head and did vitals. She said she did not document because this information was passed on to RN A and Resident #1 was not her resident. LVN C said she left the room to go back to her hall and came back to Resident #1's room to assist with the Hoyer lift. LVN C said she and RN A were able to slide the Hoyer pad underneath Resident #1. She said she, RN A, CNA A, and CNA B helped Resident #1 back to bed using the Hoyer lift. LVN C did not recall Resident #1 voicing any pain while getting transferred back to her bed.During an interview with RN A, he said when he got to Resident #1's room, Resident #1 was in a seated position. RN A said he checked Resident #1's vital signs and checked her head and body. RN A said Resident #1 was complaining of shoulder pain. RN A said he notified Resident #1's family member, the doctor and the DON. RN A said there were orders for an x-ray to Resident #1's shoulder.During an interview with LVN B on 2/4/26 at 4:46 PM, she said from what she could recall, it was reported to her that Resident #1 had fallen. LVN B said she was asked to follow up for pain on 1/7/26 for Resident #1's lower extremity, she could not recall which side. She said she asked Resident #1 if she was in pain, and Resident #1 told her yes. LVN B said Resident #1's x-ray results came back on a different shift. LVN B said Resident #1's pain to her lower extremity was what prompted the orders for the x-ray.During an interview with the DOR on 2/4/26 at 2:24 PM, he said before Resident #1 had her fall she was maximum assist x2 for transfers and moderate assist for bed mobility. The DOR said now Resident #1 is dependent for bed mobility and required 2-person assist.During an interview with the NP on 2/5/26 at 9:52 AM, she said on 1/6/26 there was an order for x-ray of Resident #1's shoulder put in and that x-ray came back negative. The NP said it was communicated to her on the morning of 1/7/26 that Resident #1 had a fall and pain in her leg. The NP said she ordered x-rays to lower extremities, and those x-rays came back negative.During an interview with the DON on 2/5/26 at 1:00 PM, she said Resident #1 initially complained of shoulder pain, then on the second day she complained of pain to bilateral hips, knees, and legs. The DON said after the fall, Resident #1 was medicated with Tylenol, and it was effective. The DON said Resident #1's baseline is alert and oriented. The DON said Resident #1 was feeding off of her roommate and constantly asking for pain meds at the same time her roommate asked for pain meds. The DON said the NP was at the facility once a week and there were no orders to send Resident #1 to the hospital.During an interview with the Administrator on 2/5/26 at 3:30 PM, she said the expectation of staff for residents having pain was to make sure they are managing the resident's pain, medicating the resident, and if the pain was not manageable, contact the doctor. The Administrator said when she spoke to the doctor, the doctor told her if there was no indication of a fracture then they managed the pain. The Administrator said on 1/15/26, the daughter found out Resident #1 fell and insisted she go to the hospital. Resident #1 did not want to go to the hospital because the pain was manageable. Resident #1 was sent to the hospital on 1/15/26. The Administrator said Resident #1 is now a 2-person assist, and staff had done a skill check on peri care and bed baths.Record review of the facility's policy titled Fall Management System, dated 04/2025 read in part . It is the policy (continued on next page)

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	675901	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cambridge Health and Rehabilitation Center	1106 Golfview Richmond, TX 77469

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F 0689 Level of Harm - Actual harm Residents Affected - Few	of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs .

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident medical records were kept in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are complete and accurately documented for one of six residents (Resident #1) reviewed for clinical records.The facility failed to ensure Resident #1's Medication Administration Record (MAR) reflected the administration of Tylenol (medication to treat pain) was accurately documented on 1/8/26.This failure could place residents at risk of not receiving the care and services needed due to inaccurate or incomplete clinical records.Findings included:Record review of Resident #1's face sheet dated 2/4/26 indicated she was a [AGE] year-old female with diagnoses of cerebral infarction (ischemic stroke caused by a blockage in brain blood vessels), displaced comminuted fracture of shaft of left femur, lack of coordination, cognitive communication deficit, reduced mobility, need for assistance with personal care, age-related osteoporosis ((a disease that causes bones to become weak and brittle), muscle weakness, other specified disorders of bone density and structure-multiple sites, and hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction affecting left non-dominant side.Record review of Resident #1's most recent comprehensive MDS dated [DATE], revealed a BIMS score of 14 which indicated cognition was intact. Further review of the comprehensive MDS indicated Resident #1 received a scheduled pain medication regimen, PRN pain medication, and non-medication intervention for pain. Resident #1 had a pain frequency and pain effect on sleep occasionally.Record review of Resident #1's quarterly MDS dated [DATE] indicated she received a scheduled pain medication regimen, PRN pain medication, and non-medication intervention for pain. Resident #1 had a pain frequency, pain effect on sleep, and pain interference with therapy activities rarely or not at all.Record review of Resident #1's orders indicated the following:-monitor level of pain using 1- 10 scale, every shift, start date 11/4/25 and an end date of 1/19/26.-Meloxicam oral tablet 15 mg- give 1 table by mouth every 24 hours as needed for pain, start date 5/14/25 and an end date of 1/19/26.-Tylenol oral tablet 325 mg- give 2 tablet by mouth every 6 hours as needed for mild pain, start date 5/13/25 and an end date of 1/19/26.-x-ray to bilateral knees, bilateral ankles, and bilateral femur STAT for post fall, order date 1/7/26. Record review of Resident #1's progress note dated 1/6/26 at 2:57 pm input by ADON A read: during bed bath resident used mobility bar to turn and misjudged the width of the bed causing her momentum to roll off the bed before staff could stop her. She landed on the floor onto her left side. Nurse assessment completed. V/S stable. She was able to [NAME] without discomfort and assisted back to bed. She states she did not hit her head. She c/o pain to left side once in bed. Medicated for discomfort.Record review of the MAR for January 2026 indicated on 1/8/26, LVN D noted a pain level of 8 under the section labeled Nocs for Resident #1.Further review of the MAR for 1/8/26 did not show Tylenol oral tablet 325 mg (Acetaminophen) was administered to Resident #1.Record review of Resident #1's progress noted dated 1/9/26 at 12:45 a.m. input by LVN D read: resident is s/p fall-c/o pain to her knee area this shift, med x1 with Apap 325 mg as ordered- tolerated well, no other c/o voiced at this time- resident alert and oriented to verbal stimuli- will continue to monitor and f/u as needed.During an interview with LVN D on 2/19/26 at 12:39 p.m., she said she gave Resident #1 Tylenol when she reported to her a pain level of 8. LVN D said when she administered the medication, Resident #1's pain level went down and if she was not mistaken Resident #1 went to sleep. LVN D said she was sure she documented in her paper tablet the pain medication she administered and not documenting in the MAR was probably an oversight. LVN D said Resident #1 was vocal and was able to let you (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know if she was in any pain. LVN D said the risk of not documenting could be overmedicating the resident.During an interview with the DON on 2/20/26 at 1:53 p.m., she said her expectation of the nurses was, if medication was given to the resident, the MAR should be marked at the same time. The DON said the risk to the resident when medication is not documented in the MAR could be someone can come behind that nurse and give the same medication again.Record review of the facility's job description for Licensed Vocational Nurse dated 12/17/2021 read in part . The primary purpose of your job position is to provide primary care to specific residents under the medical direction and supervision of the residents' attending physicians or the Medical Director of the facility, with an emphasis on assessment, illness prevention and health care management. Essential duties and responsibilities: . perform administrative duties regarding assigned residents, such as completing medical forms, reports, evaluations, studies, charting .Record review of the facility's policy titled Documentation, dated 05/2007 read in part . the resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition .