STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675991	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Humble	19424 McKay Dr Humble, TX 77338

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 5 residents (Resident #1) reviewed for quality of care.The facility failed to ensure nurses monitored Resident #1 after an unwitnessed fall on 5/1/26 according to the facility policy.The facility failed to document the monitoring of Resident #1's unwitnessed fall on 5/1/26 and 5/2/26. This failure could place residents at risk for a delay in care, injury, and hospitalization.Findings included:Record review of Resident #1's admission Record, dated 5/21/26, revealed an [AGE] year-old female admitted on [DATE]. Her diagnoses included traumatic subdural hemorrhage without loss of consciousness (is bleeding that occurs between the dura mater and the arachnoid mater of the brain), Alzheimer's disease with late onset, bilateral osteoarthritis of hip (the protective cartilage that cushions the ends of the bones wears down over time), contracture of right and left hip (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility), cognitive communication deficit, personal history of traumatic brain injury, fracture of lower end of right femur, and osteoporosis (bones to become weak and brittle).Record review of Resident #1's quarterly MDS assessment, dated 3/22/26, revealed a BIMS score of 1 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care.Record review of Resident #1's care plan, dated 3/19/26, revealed she was at high risk for falls related to a balance problem. She had an actual fall with no injury related to poor balance on 5/1/26 (revised on 5/9/26). Interventions included physical therapy to evaluate.Record review of Resident #1's nursing notes, dated 5/1/26 at 12:20 p.m. by RN R (created 5/12/26 at 3:27 p.m.), read in part, .LATE ENTRYNote Text: Writer was notified that resident was on the floor in her room. Writer went in room observed resident lying on her left side close to her bed. Resident is A&Ox3. She was able to answer question. Resident reported that she was trying to go back to bed and fell. Resident denied hitting her head on the floor but she said that she has a little pain in her left thigh, writer looked at her thigh, no bruise and no visible injuryobserved. Resident has shock (sic) on. Writer saw resident in room with volunteers 10 minutes ago. Resident reported that they was praying for her and left her in her room with the door closed. Resident has her floor matt (sic) on. resident wnl. bp 122/66 HR 67 SO2 97%RA. TEMP 97.6 ACTIVE ROM. Resident was picked up from the floor and put back in her chair. Resident reported pain and pain med administered. RP made aware. DON and (family member) notified. Resident is at the nursing station.Record review of Resident #1's nursing note, dated 5/3/26 at 3:02 p.m. by LVN G, read in part, . Resident has a bruise on Right side of jaw. Resident stated that she fell. I ask (sic) her what happened, did she fall. she said yes, she fell. and then I asked her who picked her up and she said she doesn't know. (Family member) is in her room, and other (family member) on video on the tablet. (Family member) stated that he seen (sic) her (Resident #1) in the room.During an interview on 5/21/26 at 11:21 a.m., LVN G said she was coming onto her shift on Sunday 5/3/26 and Resident #1's family member asked what happened to the resident's face and no staff (on duty) knew. She said the resident had a bruise on the jawline that appeared red, purple and blue and Resident #1 said that her jaw hurt. LVN G said Resident #1 said she (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	fell but did not know who picked her up. LVN G said no one gave her report on a fall. She said the nurse who she relieved was unaware of the fall but informed her the ADON knew what occurred and would speak to the family. LVN G said she put a progress note in the system but did not call the MD or NP at that time. She said she did not conduct an assessment because the ADON already knew about it and she was unsure if the incident was noted in the computer system prior because she did not look. She said as soon as she left Resident #1's room she left the building because the CNAs were acting unusual, and did not leave report for the next person. She said if a resident reported a fall the nursing staff were supposed to check on them, call the MD, do an incident report, and assess for any bruising. During an interview on 5/21/26 at 11:57 a.m., RN R said nursing staff always kept Resident #1 at the nursing station because she was a fall risk. On 5/1/26 two volunteers brought Resident #1 to her room, prayed with her and left her in the room with the door shut. She said a CNA discovered the resident fell and reported it to the nurse (RN R). When she arrived at the room, she assessed the resident and there was no bruising. She said the resident expressed pain in the middle of her chin and she administered Tylenol. The resident told her she did not hit her head but she started neuro checks. She reported the fall to the DON. She said she forgot to notify the resident's family member and thought she notified the provider but was unsure. The DON informed her to monitor the resident for bruising and pain in case she needed to be sent to the ER. She said when she left for the day (at 2:00 p.m.) the resident was fine. She said she did not write anything down on paper regarding the fall and was unsure what she documented in the resident's electronic medical record that day. She said the next nurse arrived late for her shift and she (RN R) was already gone. She said the manager should have reported the fall to the next nurse. She said she may have forgotten to document the fall that day and might have documented it later. She said the Unit Manager called her later to ask what happened and said she did not document it. She said if the resident had no injuries the fall protocol was to notify the family, MD and monitor to see if there were any symptoms of pain.During an interview on 5/21/26 at 1:26 p.m., LVN L said she was Resident #1's nurse on 5/2/26 and 5/3/26 from 6:00 a.m. - 2:00 p.m. She said she was made aware of the fall on Saturday (5/2/26) but could not recall from whom. She said the resident was fine on Saturday and had no bruise or pain. She said she checked Resident #1's vital signs, conducted neuros and asked if she was in pain. She said she forgot to document anything about the resident's fall in the medical record and did not know why. She said after a fall, nurses should document, conduct neuros, vital signs, and assess for injuries and pain. She said the facility did provide an in-service on falls and documentation that following Monday, 5/4/26, after the incident.During an interview on 5/21/26 at 1:43 p.m., the DON said on 5/1/26 she went to Resident #1's room with RN R and saw the resident on the floor. She said the resident was assessed and did not have pain at the time and there were no bruises at the time. She said she left the room and RN R took over the incident. She said on Sunday, 5/3/26, she received a phone call from the facility that Resident #1's family member was upset because of the bruising on her face and that no one notified them. She said some documentation regarding Resident #1's fall was missing in the chart and on 5/3/26 the Unit Manager contacted RN R to ensure it was completed. She said there was a conversation with the nurses on ensuring documentation was done but nothing was documented on paper. During an interview on 5/21/26 at 2:30 p.m., LVN B said she worked with Resident #1 on 5/2/26 and was not aware she fell because she was not notified. She said she did not monitor her for falls during her shift and did not conduct neuro checks. She said she was normally notified of falls through the 24-hour report or through shift change report. She said after a resident falls, nursing staff conduct a fall follow up for 3 days and document in the electronic medical record. She said Resident #1 was a fall risk and was at her baseline on Saturday (5/2/26) with no changes noticed.During an interview on 5/21/26 at 2:38 p.m., the Unit Manager said she was unaware about Resident #1's fall on 5/1/26 and 5/2/26. She said on Sunday, 5/3/26, she saw on the 24 hour report that neuro checks were initiated but not locked in the system. She said concerns were noted with the documentation on this fall. She said she called RN R so she could do the documentation. During an interview on 5/21/26 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 3:17 p.m., the DON said for a fall, nursing staff should assess the resident for injuries, pain, provide medication, ask them what happened/what were you trying to do and notify the family and MD. She said neuro checks should be started if it was an unwitnessed fall. The DON said the follow up documentation included status post 1-3 days per shift. She said the follow up included monitoring for any bruising that occurred, complaints of pain, and ensuring the resident was not trying to do the activity they were doing prior to falling. She said communication from shift to shift should be on the 24 hour sheet and verbal person to person she be conducted when doing rounds. She said she was unsure if the nurse on the 2:00 p.m. - 10:00 p.m. shift on 5/1/26 was notified of Resident #1's fall and said she did not inform her because that was not something she did. She said if the information on the fall was not given during report the next shift nurse could check the documentation. She said if there was no documentation the next shift would not know. She said a conversation was had with the nurses on proper documentation, status post monitoring, and communicating with one another about the falls but there was no record of that. She said the Unit Manager, ADON, and DON provided oversight to ensure the documentation was done. During an interview on 5/21/26 at 4:46 p.m., the Administrator said he expected nursing staff to start the documentation right away, start neuro checks, notify the MD and RP, and pass the information on to the next shift and monitor the resident for the next three days. He said the fall process was in place to ensure there were no major injuries following a fall, including bruises. The Administrator said the risk of not following the process would include missing a change in condition.Record review of the facility's policy titled, Assessing Falls and Their Causes, dated October 2010 read in part, .The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Steps in the Procedure.After a Fall: 5. Nursing staff will observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record. 6. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings. 7. An incident report must be completed for resident falls. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services no later than 24 hours after the fall occurs. Defining Details of Falls: 1. After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred.

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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 maintain medical records on each resident that were complete, accurately documented, readily and systematically organized in accordance with accepted professional standards and practices for 1 of 5 residents (Resident #1) reviewed for clinical records.The facility failed to document the monitoring of Resident #1's unwitnessed fall on 5/1/26 and 5/2/26 in a timely manner. This failure could place residents at risk for a delay in care, injury, and hospitalization.Findings included:Record review of Resident #1's admission Record, dated 5/21/26, revealed an [AGE] year-old female admitted on [DATE]. Her diagnoses included traumatic subdural hemorrhage without loss of consciousness (is bleeding that occurs between the dura mater and the arachnoid mater of the brain), Alzheimer's disease with late onset, bilateral osteoarthritis of hip (the protective cartilage that cushions the ends of the bones wears down over time), contracture of right and left hip (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to restricted joint mobility), cognitive communication deficit, personal history of traumatic brain injury, fracture of lower end of right femur, and osteoporosis (bones to become weak and brittle).Record review of Resident #1's quarterly MDS assessment, dated 3/22/26, revealed a BIMS score of 1 out of 15 which indicated severe cognitive impairment. She required assistance from staff with ADL care.Record review of Resident #1's care plan, dated 3/19/26, revealed she was at high risk for falls related to a balance problem. She had an actual fall with no injury related to poor balance on 5/1/26 (revised on 5/9/26). Interventions included physical therapy to evaluate.Record review of Resident #1's nursing notes, dated 5/1/26 at 12:20 p.m. by RN R (created 11 days later on 5/12/26 at 3:27 p.m.), read in part, .LATE ENTRYNote Text: Writer was notified that resident was on the floor in her room. Writer went in room observed resident lying on her left side close to her bed. Resident is A&Ox3. She was able to answer question. Resident reported that she was trying to go back to bed and fell. Resident denied hitting her head on the floor but she said that she has a little pain in her left thigh, writer looked at her thigh, no bruise and no visible injury observed. Resident has shock (sic) on. Writer saw resident in room with volunteers 10 minutes ago. Resident reported that they was praying for her and left her in her room with the door closed. Resident has her floor matt (sic) on. resident wnl. bp 122/66 HR 67 SO2 97%RA. TEMP 97.6 ACTIVE ROM. Resident was picked up from the floor and put back in her chair. Resident reported pain and pain med administered. RP made aware. DON and (family member) notified. Resident is at the nursing station.Record review of Resident #1's nursing note dated 5/1/26 at 2:14 p.m. by RN R (created 2 days later on 5/3/26 at 3:49 p.m.), read in part, .resident is at the nursing station. writer went and asked if she is still in pain. Resident denied pain or discomfort. Resident has no visible injury, will be monitoring . Record review of Resident #1's nursing note, dated 5/3/26 at 3:02 p.m. by LVN G, read in part, . Resident has a bruise on Right side of jaw. Resident stated that she fell. I ask (sic) her what happened, did she fall. she said yes, she fell. and then I asked her who picked her up and she said she doesn't know. (Family member) is in her room, and other (family member) on video on the tablet. (Family member) stated that he seen (sic) her (Resident #1) in the room.Record review of Resident #1's Pain Assessment regarding her fall on 5/1/26 revealed it was dated 5/1/26 but created 2 days later on 5/3/26 by RN R. Record review of Resident #1's Neurological Assessment regarding her fall on 5/1/26 revealed it was dated 5/1/26 but created 2 days later on 5/3/26 by RN R. Record review of Resident #1's Fall Risk Assessment regarding her fall on 5/1/26 revealed it was dated 5/1/26 but created 2 days later on 5/3/26 by RN R. During an interview on 5/21/26 at 11:21 a.m., LVN G said she was coming onto her shift on Sunday 5/3/26 and Resident #1's family member asked what happened to the resident's face and no staff (on duty) knew. She said the resident had a bruise on the jawline that appeared red, purple and blue and Resident #1 said that her jaw hurt. LVN G said Resident #1 said she fell but did not know who picked (continued on next page)

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	675991	A. Building B. Wing	05/21/2026

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Park Manor of Humble	19424 McKay Dr Humble, TX 77338

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her up. LVN G said no one gave her report on a fall. She said the nurse who she relieved was unaware of the fall but informed her the ADON knew what occurred and would speak to the family. LVN G said she put a progress note in the system but did not call the MD or NP at that time. She said she did not conduct an assessment because the ADON already knew about it and she was unsure if the incident was noted in the computer system prior because she did not look. She said as soon as she left Resident #1's room she left the building because the CNAs were acting unusual, and did not leave report for the next person. She said if a resident reported a fall the nursing staff were supposed to check on them, call the MD, do an incident report, and assess for any bruising. During an interview on 5/21/26 at 11:57 a.m., RN R said nursing staff always kept Resident #1 at the nursing station because she was a fall risk. On 5/1/26 two volunteers brought Resident #1 to her room, prayed with her and left her in the room with the door shut. She said a CNA discovered the resident fell and reported it to the nurse (RN R). When she arrived at the room, she assessed the resident and there was no bruising. She said the resident expressed pain in the middle of her chin and she administered Tylenol. The resident told her she did not hit her head but she started neuro checks. She reported the fall to the DON. She said she forgot to notify the resident's family member and thought she notified the provider but was unsure. The DON informed her to monitor the resident for bruising and pain in case she needed to be sent to the ER. She said when she left for the day (at 2:00 p.m.) the resident was fine. She said she did not write anything down on paper regarding the fall and was unsure what she documented in the resident's electronic medical record that day. She said the next nurse arrived late for her shift and she (RN R) was already gone. She said the manager should have reported the fall to the next nurse. She said she may have forgotten to document the fall that day and might have documented it later. She said the Unit Manager called her later to ask what happened and said she did not document it. She said if the resident had no injuries the fall protocol was to notify the family, MD and monitor to see if there were any symptoms of pain.During an interview on 5/21/26 at 1:26 p.m., LVN L said she was Resident #1's nurse on 5/2/26 and 5/3/26 from 6:00 a.m. - 2:00 p.m. She said she was made aware of the fall on Saturday (5/2/26) but could not recall from whom. She said the resident was fine on Saturday and had no bruise or pain. She said she checked Resident #1's vital signs, conducted neuros and asked if she was in pain. She said she forgot to document anything about the resident's fall in the medical record and did not know why. She said after a fall, nurses should document, conduct neuros, vital signs, and assess for injuries and pain. She said the facility did provide an in-service on falls and documentation that following Monday, 5/4/26, after the incident.During an interview on 5/21/26 at 1:43 p.m., the DON said on 5/1/26 she went to Resident #1's room with RN R and saw the resident on the floor. She said the resident was assessed and did not have pain at the time and there were no bruises at the time. She said she left the room and RN R took over the incident. She said on Sunday, 5/3/26, she received a phone call from the facility that Resident #1's family member was upset because of the bruising on her face and that no one notified them. She said some documentation regarding Resident #1's fall was missing in the chart and on 5/3/26 the Unit Manager contacted RN R to ensure it was completed. She said there was a conversation with the nurses on ensuring documentation was done but nothing was documented on paper. During an interview on 5/21/26 at 2:30 p.m., LVN B said she worked with Resident #1 on 5/2/26 and was not aware she fell because she was not notified. She said she did not monitor her for falls during her shift and did not conduct neuro checks. She said she was normally notified of falls through the 24-hour report or through shift change report. She said after a resident falls, nursing staff conduct a fall follow up for 3 days and document in the electronic medical record. She said Resident #1 was a fall risk and was at her baseline on Saturday (5/2/26) with no changes noticed.During an interview on 5/21/26 at 2:38 p.m., the Unit Manager said she was unaware about Resident #1's fall on 5/1/26 and 5/2/26. She said on Sunday, 5/3/26, she saw on the 24 hour report that neuro checks were initiated but not locked in the system. She said concerns were noted with the documentation on this fall. She said she called RN R so she could do the documentation. During an interview on 5/21/26 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 3:17 p.m., the DON said for a fall, nursing staff should assess the resident for injuries, pain, provide medication, ask them what happened/what were you trying to do and notify the family and MD. She said neuro checks should be started if it was an unwitnessed fall. The DON said the follow up documentation included status post 1-3 days per shift. She said the follow up included monitoring for any bruising that occurred, complaints of pain, and ensuring the resident was not trying to do the activity they were doing prior to falling. She said communication from shift to shift should be on the 24-hour sheet and verbal person to person she be conducted when doing rounds. She said she was unsure if the nurse on the 2:00 p.m. - 10:00 p.m. shift on 5/1/26 was notified of Resident #1's fall and said she did not inform her because that was not something she did. She said if the information on the fall was not given during report the next shift nurse could check the documentation. She said if there was no documentation the next shift would not know. She said a conversation was had with the nurses on proper documentation, status post monitoring, and communicating with one another about the falls but there was no record of that. She said the Unit Manager, ADON, and DON provided oversight to ensure the documentation was done. During an interview on 5/21/26 at 4:46 p.m., the Administrator said he expected nursing staff to start the documentation right away, start neuro checks, notify the MD and RP, and pass the information on to the next shift and monitor the resident for the next three days. He said the fall process was in place to ensure there were no major injuries following a fall, including bruises. The Administrator said the risk of not following the process would include missing a change in condition.Record review of the facility's policy titled, Assessing Falls and Their Causes, dated October 2010 read in part, .The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Steps in the Procedure.After a Fall: 5. Nursing staff will observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record. 6. Documentation will include any observed signs or symptoms of pain, swelling, bruising, deformity, and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. It will note the presence or absence of significant findings. 7. An incident report must be completed for resident falls. The incident report form should be completed by the nursing supervisor on duty at the time and submitted to the Director of Nursing Services no later than 24 hours after the fall occurs. Defining Details of Falls: 1. After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred.