STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676152	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seven Acres Jewish Senior Care Services	6200 N Braeswood Blvd Houston, TX 77074

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who were unable to carry out Activities of Daily Living received the necessary services to maintain grooming and personal hygiene for 4 (Resident #2, Resident #3, Resident #4 and Resident #5) of 10 residents reviewed for Activities of Daily Living.The facility failed to provide Residents #2, Resident #3, Resident #4 and Resident #5 with adequate services to maintain personal hygiene that included incontinence care and periodic turning and repositioning. This failure could place residents at risk of diminished quality of life, decreased self-esteem or skin breakdown. Findings included: Record review of Resident #2's face sheet dated 2/26/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction (stroke). Record review of Resident #2's quarterly MDS dated [DATE], section C revealed a BIMS interview could not be conducted as the resident was rarely or never understood. Section GG revealed Resident #2 was dependent regarding toileting hygiene. Section H revealed Resident #2 always had urinary incontinence. Record review of Resident #2's care plan as of 2/26/26 revealed category of urinary incontinence with approach start date of 8/30/24 to check for incontinent episodes at least every 2 hours. Record review of Resident #2's Weekly Skin assessment dated [DATE] revealed an arterial ulcer on her left second toe but no other skin breakdown. During interview on 2/24/26 at 11:34 a.m., Resident #2's family member said on 2/4/26 there were 14 hours that Resident #2 was not changed. Resident #2's family member said Resident #2 was last changed around 9 p.m. on 2/3/26, and was not changed until the day and was not changed by the overnight staff. Resident #2's family member said there was a camera in Resident #2's room and that was how they knew Resident #2 was not changed. Resident #2's family member said that this had been the first time that Resident #2 had not been changed in a while but was had been an ongoing issue with the overnight staff with them not checking residents and changing them. Resident #2's family member said it had been about a year and a half with no issues but since December 2025 it had been one issue after another. Observation on 2/25/26 at 9:36 a.m. revealed Resident #2 was clean and dressed lying in bed with her eyes closed and no foul odors noted. Observation and an attempted interview on 2/25/26 at 10:01 a.m. revealed Resident #2 was clean and dressed sitting in a wheelchair in her room. Resident #2 vocalized noises but did not speak words or shake her head yes or no to questions. Observation on 2/26/26 at 8:58 a.m. revealed Resident #2 was clean and dressed lying in bed with her eyes closed and no foul odors noted. Resident #3Record review of Resident #3's face sheet dated 2/26/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia (group of symptoms affecting memory, thinking and social abilities.)Record review of Resident #3's annual MDS dated [DATE], section C revealed a revealed a BIMS score of 14 that indicated cognition was intact. Section GG revealed Resident #3 was dependent regarding toileting hygiene. Section H revealed Resident #3 always had urinary incontinence. Record (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #3's care plan as of 2/26/26 revealed category of urinary incontinence with approach start date of 12/10/25 to check for incontinent episodes at least every 2 hours. Record review of Resident #3's Weekly Skin assessment dated [DATE] revealed Resident #3 had no skin breakdown noted. During interview and observation on 2/24/26 at 12:31 p.m., Resident #3 was clean and dressed sitting in a wheelchair in her room with no foul odors noted. Resident #3 said her care was terrible. Resident #3 said they do not have enough help and the help they do have had lax ability. Resident #3 said she wears a diaper. Resident #3 said the second shift would say it was the third shift's job, and the third shift would say it was the second shift's job. Resident #3 answered yes when asked if she had problems with the overnight shift not checking on her or changing her. Resident #3 said it was recent when the overnight shift last did not check on her, but she thought it was the week before last. Resident #3 said it depended on who was on the overnight shift and some were good and some were not and it was the same as the day shift. Resident #3 said it happened about three to four times a month that the overnight shift did not check on her.Resident #4Record review of Resident #4's face sheet dated 2/26/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (progressive brain disorder that destroys memory and thinking skills).Record review of Resident #4's annual MDS dated [DATE], section C revealed a BIMS score of 7 that indicated moderate cognitive impairment. Section GG revealed Resident #4 was dependent regarding toileting hygiene. Section H revealed Resident #4 always had urinary incontinence. Record review of Resident #4's care plan as of 2/26/26 revealed category of urinary incontinence with approach start date of 12/22/25 to check for incontinent episodes at least every 2 hours. Record review of Resident #4's Weekly Skin assessment dated [DATE] revealed Resident #4 had no skin breakdown noted. Record review of Grievance/Complaint Report dated 2/5/26 revealed grievance regarding Resident #4 by a family member that Resident #4 was not provided with incontinent care from 11-7 shift. Resolution included that Resident #4 was assessed with no skin breakdown noted, in-service provided to staff and the two CNAs who were assigned and unnamed in the grievance to the resident received verbal warnings. During interview on 2/24/26 at 9:25 a.m., Resident #4's family member said Resident #4 was not changed for 14 hours and 37 minutes overnight 2/3-2/4/26 which was obtained this information from camera footage in Resident #4's room. Resident #4's family member said Resident #4 was not changed on 2/4/26 until she notified the CNA. Record review of email 2/24/26 at 11:46 a.m. from dated Resident #4's family member per their documentation revealed Resident #4's diaper was changed on 2/3/26 at 10:04 p.m. Resident #4's family member arrived at the facility and found Resident #4 soaked and documented Resident #4 had not been changed in 14 hours and 37 minutes. Record review of email from Resident #4's family member dated 2/24/26 at 11:50 a.m. revealed screen shot of all the clips from camera in Resident #4's room from 12 a.m. to 6 a.m. on 2/4/26. Events from camera footage for Resident #4 on 2/4/26 revealed events with screenshots at 12:54 a.m. of 12 seconds, 4:18 a.m. of 12 seconds and 6:01 a.m. of 31 seconds but no staff members were present in the footage. Screenshot at 12:54 a.m. revealed the lights were dimmed in the room and Resident #4 and Resident #5 can be seen lying in bed covered by linens. Screenshot at 4:18 a.m. revealed the lights were dimmed in the room and Resident #4 and Resident #5 can be seen lying in bed covered by linens. Screenshot at 6:01 a.m. revealed Resident #4 and Resident #5 lying in bed covered by blankets and an unknown staff member is standing at the door of the room. Observation on 2/25/26 at 9:37 a.m. revealed Resident #4 was clean and dressed lying in bed with her eyes closed and no foul odors noted. During interview on 2/25/26 at 9:49 a.m., Resident #4 said her care was so far so good. Resident #4 denied any problems with staff not checking on her or not changing her. Resident #4 kept closing her eyes during the interview. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 2/26/26 at 8:59 am., Resident #4 was clean and dressed lying in bed with no foul odors noted. When Resident #4 was asked if someone checked on her last night, she replied what for?Resident #5Record review of Resident #5's face sheet dated 2/26/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (group of symptoms affecting memory, thinking and social abilities).Record review of Resident #5's quarterly MDS dated [DATE], section C a BIMS interview could not be conducted as the resident was rarely or never understood. Section GG revealed Resident #5 was dependent regarding toileting hygiene. Section H revealed Resident #5 always had urinary incontinence. Record review of Grievance/Complaint Report dated 2/5/26 revealed grievance regarding Resident #5 by a family member that Resident #5 was not provided with incontinent care on 2/4/26 during the 11-7 shift. Resolution included that in-service was provided and Resident #5 was assessed with no redness or breakdown observed. Record review of Resident #5's care plan as of 2/26/26 revealed category of urinary incontinence with approach start date of 6/19/25 to check for incontinent episodes at least every 2 hours. Record review of Resident #5's Weekly Skin assessment dated [DATE] revealed Resident #5 had no skin breakdown noted. Record review of video footage received from Resident #4's family member 2/3-2/4/26 revealed the times staff members were present in Resident #4's room on 2/3/26 at 10:04 p.m. and next time occurring on 2/4/26 at 12:40 p.m. On 2/3/26 at 10:04 p.m., staff member was observed appearing to have recently changed Resident #4's diaper as there is a diaper in a bag. On 2/4/26 at 12:40 p.m., two staff members are observed changing Resident #4's diaper. Record review of email dated 2/25/26 from Resident #5's family member revealed the following timeline of events from 2/3-2/4/26 from reviewing camera footage in Resident #5's room: 2/3/26 at 8:35 p.m. - Resident #5 was placed in bed 2/3/26 at 8:40 p.m. - Resident #5's diaper was changed 2/4/26 at 7:24 a.m. - Staff adjusted Resident #5's blanket but did not check her diaper 2/4/26 at 9:13 a.m. - Resident #5 was fed but diaper was not checked 2/4/26 at 12:58 p.m. - Resident #5's diaper was changed During interview on 2/25/26 at 2:31 p.m., Resident #5's family member said Resident #5 was put to bed and was not checked or changed that whole night from 2/3-2/4/26. Resident #5's family member said the person who came in that next morning did not change Resident #5 until the next morning and had gone almost 14 hours without being changed. Resident #5's family member saidshe had written in her notes that Resident #5 was put to bed at 8:30 p.m. on 2/3/26 and was not changed until 12:45 p.m. on 2/4/26. Resident #5's family member said Resident #5 should have been out of bed and done with lunch by 12:45 p.m. Resident #5's family member said she knew Resident #5 had gone 14 hours without being changed because there was camera in Resident #5's room and they had reviewed the footage. Resident #5's family member said her main concern was that there was no system in place and that it could happen again. During interview on 2/25/26 at 9:54 a.m., Resident #5 was clean and dressed lying in bed with eyes closed and no foul odors noted. Observation on 2/26/26 at 8:59 a.m. revealed Resident #5 was clean and dressed lying in bed with her eyes closed and no foul odors noted. A staff member was feeding Resident #5 breakfast. Record review of Daily Staffing Sheet from 11P-7A on 2/3/2026 revealed CNA B was scheduled on the unit with Resident #2, Resident #3, Resident #4 and Resident #5 but did not list specific room assignments. Record review of Personnel Action Form that was undated for CNA B revealed termination as of 2/5/26. During interview on 2/26/26 at 1:44 p.m., CNA B said she was given her schedule of residents in writing of which she was supposed to attend to which she did. CNA B said she gave the vital signs of the residents she was assigned to the nurse, and no one ever told her that there were other patients assigned to me. CNA B said when she was being questioned by the DON regarding care (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not being given, she was told by the DON that there was a list of assignments at the nurses' station and CNA B said she was a new staff and did not know that. CNA B said she had cleaned Resident #4 and Resident #5 many times and did not have a problem cleaning the residents. CNA B said on the night of 2/3/25 she did the residents' vital signs and cared for the residents she was assigned to. CNA B said she did not neglect any residents. During interview on 2/25/26 at 1:00 p.m., CNA C said she worked on the unit with Resident #2, Resident #3, Resident #4 and Resident #5 from 7 a.m. to 3 p.m. CNA C said they were not working on 2/4/26. CNA C said when they came in the morning sometimes the residents were clean and dry depending on what time the night shift started changing them because they would start changing them at 5-6 a.m. if they were heavy wetters. CNA C denied any of the residents being wet or concerns regarding night shift not changing residents as sometimes when they were coming in they were still changing residents. CNA C said they rounded on the residents twice per shift. CNA C denied any concerns regarding neglect at this time. During interview on 2/25/26 at 1:13 p.m., CNA D said she worked from 7 a.m. to 3 p.m. and worked on 2/4/26 but could not remember which unit they worked. CNA D denied any concerns with the residents not being changed on the night shift. CNA D denied any concerns regarding neglect currently. During interview on 2/25/26 at 1:22 p.m., CNA E said they worked from 7 a.m. to 3 p.m. and worked on 2/4/26 but could not remember which unit they worked. CNA E denied any concerns about residents not being changed overnight. CNA E said if she was not busy, she checked on residents every hour. CNA E denied any concerns regarding neglect of residents. During interview on 2/25/26 at 1:30 p.m., CNA F said when she came in the mornings if residents were wet she helped the night shift change the residents. CNA F said for the most part everybody was clean when she came in and it was a rarity that she found residents dirty and did not remember anything abnormal about 2/4/26 when she came in that day. CNA F said the requirement was every two hours to round on residents who were incontinent but could be more if needed. CNA F denied any concerns regarding neglect currently because she said if she saw something she would tell especially if it was bringing harm to a patient. During interview on 2/25/26 at 1:47 p.m., the Unit Manager said she was probably working on 2/4/26. The Unit Manager said she just had a complaint from Resident #4's family member that Resident #4 had not been changed and she believed Resident #5's family member had also made a complaint as well. The Unit Manger said she spoke to DON, and they performed an in-service and the DON let that person go. The Unit Manager said the complaints were related to the 11-7 shift going into 2/4/26 probably, but she would have to check. The Unit Manager denied any concerns regarding abuse or neglect of the residents currently. During interview on 2/26/26 at 10:02 a.m., the DON said she was aware that Resident #4 and Resident #5 were not changed on the night of 2/3/26. The DON said she talked to CNA B and CNA B said she did not look at the assignment at the nurses' station and another CNA had given CNA B a piece of paper with her assignment and it did not have the room numbers for Resident #4 and Resident #5. The DON said she terminated CNA B. The DON said we went ahead and did an in-service with all shifts to make sure they did rounds and the nurses check on the staff and make sure they were doing what they were supposed to do. The DON said when the CNAs were hired, they go to the classroom training and then go on the unit for three days with certain CNA mentors who have been here a long time. During interview on 2/26/26 at 12:16 p.m., the DON said if residents' diapers were not changed, they could have skin breakdown. Record review of facility's policy Incontinent Care last reviewed 6/6/25 revealed Incontinent monitoring will be conducted by round every two to three hours per shift.

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F 0689 Level of Harm - Minimal harm or potential for 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 1 (Resident #1) of 10 residents reviewed for accidents and hazards.The facility failed to ensure that CNA A used a full body lift instead of a standing lift as instructed on Resident #1's care plan and had two staff members present when using a mechanical lift when transferring Resident #1 on 2/19/26. The failure could place residents at risk of possible injury. Findings included: Record review of Resident #1's face sheet dated 2/26/26, revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness of the right side following a stroke). Record review of Resident #1's annual MDS dated [DATE], section C revealed a BIMS score of 8 that indicated moderate cognitive impairment. Section GG revealed Resident #1 was dependent for chair/bed to chair transfers.Record review of Resident #1's orders did not reveal any information related to transferring or mechanical lifts. Record review of Resident #1's care plan as of 2/26/26 revealed categories as follows: *ADLs Functional for Resident #1 limited in their ability to transfer due to impaired mobility and required to be assisted with transferring using the full body life and was 2 person assistance with approach start date of 2/19/26. *ADLs Functional with approach start date of 3/27/24 that says I will be assisted with transferring using the Full body lift, 2 person assist with approach start date of 3/27/24. Record review of written statement by CNA A on 2/19/26 revealed when CNA A did not find a full body sling in Resident #1's room they used the standing lift to transfer Resident #1. CNA A wrote Resident #1 chose to sit on the floor and CNA A slowly lowered Resident #1 to the floor. CNA A wrote that Resident #1 did not complain about anything at that time. Record review of written statement by RN A on 2/19/26 revealed they assessed Resident #1 from head to toe, and no injury was found and Resident #1 denied pain at the time the resident was found to be on the floor.Record review of Resident #1's progress notes written by RN A dated 2/19/26 at 4:52 p.m. revealed Resident #1 denied pain when assessed at the time she was on the floor after transferring. Record review of Resident #1's hospital records dated 2/19/26 revealed results of a head CT of no acute intracranial (within the skull) abnormality and right shoulder x-ray that showed no acute findings. Record review of Resident #1's progress notes written by LVN A dated 2/20/26 at 6:47 a.m. revealed Resident #1 was assessed at a hospital and Resident #1's skin remained intact with no injuries noted. Resident #1 was not found to have fractures per hospital discharge papers and no new orders. Record review of Resident #1's NP Progress Note SNF Follow Up dated 2/20/26 revealed Resident #1 was evaluated at the hospital with negative findings after a transfer incident in which Resident #1 was reportedly lowered to the ground. Progress note revealed no pain and review of systems was otherwise unremarkable aside from chronic generalized weakness. During interview on 2/25/26 at 1:47 p.m., the Unit Manager said there were always two people when transferring residents with the standing or full body lift. During interview on 2/26/26 at 9:03 a.m., Resident #1 said regarding when she fell on the floor, it was Thursday a week ago. Resident #1 said they used a lift that was not a good lift and was an older lift and they tried to move me to the wheelchair, and I fell before I got to the wheelchair. Resident #1 said she felt like her legs were hurt but they send her to the hospital and did not find anything. Resident #1 said there were two staff members when they were moving her with the lift when she fell. During interview on 2/26/26 at 10:02 a.m., the DON said she was at the facility during the incident with Resident #1 on 2/19/26. The DON said the aide said it was time for Resident #1 to get up for lunch, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the aide was looking for the sling for the full body lift and could not find the sling, so the aide took the standing lift to the room. The DON said that in the process of transferring Resident #1 from the bed to the chair the aide had to lower Resident #1 to the floor and the aide notified the charge nurse. The DON said the charge nurse came and assessed Resident #1 and Resident #1 did not complain of any pain at that time. The DON said at about 3 p.m. Resident #1 complained of right shoulder and bilateral knee pain and we notified the doctor of what happened with the transfer and the doctor said to send Resident #1 to the ER for an evaluation. The DON said the CNA's name was CNA A. The DON said CNA A admitted on her statement that she did not follow Resident #1's plan of care and her excuse was that she could not find the sling. The DON said she terminated CNA A. The DON said we had a sheet for the lifts that said to follow the care plan. The DON said we trained everyone again regarding lifts except nine employees that were either on medical leave or on vacation. On 2/26/26 at 11:51 a.m., surveyor attempted to contact RN A via phone but was unsuccessful and left a message to call surveyor but did not receive a call back. During interview on 2/26/26 at 11:54 a.m., CNA A said on 2/19/26 she lowered Resident #1 to the floor and Resident #1 did not fall. CNA A said Resident #1 did not complain of anything at the time of the incident. CNA A said no one was helping her with the standing lift when she was transferring Resident #1 because they were all busy and there were only a few staff. CNA A said there was usually someone who could come to help her transfer residents. CNA A said when we were not busy, they use two people. CNA A said she had received training regarding how to use the lifts when she was hired. CNA A said it was her first time taking care of Resident #1 and she did not know she was not supposed to use the standing lift for Resident #1. CNA A said that if the full body lifts were busy, she would use the standing lift to transfer residents. During interview on 2/26/26 at 12:16 p.m., the DON said if only one person was using a lift you may not be able to complete the transfer and there was a potential for injury.Record review of CNA A's employee profile revealed termination with effective date of 2/19/2026. Record review of CNA A's Mechanical Lift in-service dated 1/2/26 revealed CNA A signed their initials indicating topics of the use of the correct lift despite family request and two person assist for all lift transfers was discussed in detail. Total Mechanical Lift and Sit/Stand Mechanical Lift Competency checklists were also completed.Record review of the facility's Mechanical Lift In-services revealed training regarding use of the correct lift despite family request and two person assist for all lift transfer for staff members from 2/19-2/25/26.Record review of Attendance Record for subject Abuse and Neglect revealed training was completed with staff members from 2/19-2/21/26. Record review of the facility's policy Transfer Techniques reviewed last on 2/12/25 revealed the nursing staff were to ensure the correct lift is being used and all residents require 2 person transfer with lift equipment at Seven Acres.