STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676153	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of League City	2620 W Walker League City, TX 77573

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 (CR #1) of 4 residents reviewed for notification of changes. 1. On [DATE], LVN B and LVN C failed to notify the physician when CR#1 had a significant change in condition where he refused all meals, had increased drowsiness, and had hypotensive BP readings of 89/59 at 2:31 p.m. and 86/57 at 7:08 p.m. 2. On [DATE], CR#1 was sent to the hospital due to unresponsiveness and was placed in ICU. He required several rounds of CPR and was diagnosed with a blood infection, septic shock, and suffered an acute stroke.On [DATE] at 1:47 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated and due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition and/or infection, stroke, or death. Findings included:Record review of CR#1's face sheet, dated [DATE], documented a [AGE] year-old male, admitted [DATE]. His admitting diagnoses were Type 2 Diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), presence of cardiac implants and grafts (cardiovascular surgery where artificial devices were inserted), morbid severe obesity due to excess calories, hypertension (high blood pressure), cerebral infarction (stroke), and he was a full code (a medical directive indicating that in the event of a cardiac or respiratory arrest, all possible life-saving interventions)Record review of CR#1's care plan, dated [DATE], documented CR#1 had chronic health issues and comorbid conditions that may further affect his quality of life. Interventions stated to monitor vital signs and report all changes in condition to a doctor.Record review of CR#1's vital signs on [DATE], MA B documented CR#1's BP was 89/59 at 2:31 p.m. and 86/57 at 7:08 p.m. Record review of CR#1's CIC assessments documented no CIC assessment completed on [DATE]. Record review of CR#1's progress notes dated [DATE] revealed no documentation that CR#1's the physician had been notified regarding a change in condition. Record review of CR#1's progress note dated [DATE] at 10:53 a.m. created by LVN A, revealed that upon entering CR#1's room, he appeared asleep with minimal communication. CR#1 did not attempt to eat breakfast, he was barely responsive, and clammy to touch. Record review further revealed LVN A noted CR#1's BP to be low at 75/54 and he was unresponsive to a sternal rub. Record review revealed the resident was sent out due to an acute change in condition, hypotension (abnormally low blood pressure below 90/60 that indicates blood if not flowing adequately to the organs), increased work in breathing, and unresponsiveness. EMS was called, provider (a licensed person or organization that provides health care services such as doctor or NP) notified, DON notified, and family made aware of discharge.During an interview on [DATE] at 9:05 a.m., the PMD stated CR#1 was found unresponsive to a hard sternal rub (an emergency medical technique used to assess a patient's responsiveness by applying firm, grinding pressure with knuckles to the center of the chest or (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	sternum) and his BP reading was low. The PMD stated CR#1 had vomit around his mouth and he looked like he had been deteriorating for hours. He stated that CR#1 technically passed away twice in the hospital but he was resuscitated.During an observation and interview on [DATE] at 9:35 a.m., CR#1 was seen intubated in the ICU. He could not open his eyes, but he raised his eyebrows when his name was called. The HRN stated CR#1 was admitted due to unresponsiveness and they had to do three rounds of CPR because his heart stopped. On [DATE], CT (an imaging test that helps healthcare providers detect diseases and injuries) and MRI (a medical imaging technique used in radiology to generate pictures of the anatomy and the physiological processes inside the body) scans results showed that he had an infarct (presence indicates a disruption in blood flow to the brain, leading to cell death). The HRN stated cultures were also taken and results showed that he had an infection in the blood. The HRN stated CR #1 was currently sedated but was responsive to pain, tried to open his eyes to speech, and his pupils reacted to light. The FM, who was in the room, stated CR #1 wiggled his toes the day before. During an interview on [DATE] with HNP at 10:02 a.m., she stated that CR#1's hospital documentation revealed that he was found positive for a blood infection (still awaiting detailed results), septic shock, mucus in his lungs, and CT scans revealed he suffered an acute stroke. When they checked his blood sugar, it was 63 and the normal range should be above 70. The HNP stated she could not state which diagnosis was responsible for his unresponsiveness, but stated it was caused by many factors. During an interview on [DATE] at 10:06 a.m., CR#1's FM stated CR#1 suffered a stroke over a year ago that affected his mobility but his mind was very sharp. She stated she was grateful LVN A went back to check on him inside his room at the nursing facility and stated, LVN A probably saved CR#1's life. During an interview on [DATE] at 12:17 p.m., LVN A stated that she worked on [DATE] from 6:00 a.m.- 6:0 p.m. LVN A stated that when she arrived on shift LVN C informed her that CR#1 slept throughout the night and he would respond that he was ok but seemed really tired. LVN A stated when she on CR #1, she knew something was different because he was usually alert and oriented x3-4 (alert and oriented to person, place, time, and situation) and he was able to communicate his needs but he was drowsy and barely spoke. She stated his breakfast tray was untouched and that was unlike him. LVN A stated a medication aide and LVN A agreed CR #1 looked clammy, BP was low, and his blood sugar was 77. LVN A stated 911 was called and he was still unresponsive upon arrival of EMT. LVN A stated EMT replaced his CPAP (keeps your airways open while you sleep so you can receive the oxygen you need) with a non-rebreather mask (used for patients needing high-flow oxygen, such as in severe respiratory distress, trauma, or emergencies) and CR #1 was taken to the hospital. During an interview on [DATE] at 12:23 p.m., CNA D stated he worked from 6:00 a.m.- 2:00 p.m. on [DATE]. He stated CR#1 normally liked to play on his computer but he did not play on it on [DATE] and slept the majority of the day. CNA D described CR#1 as very sleepy and stated CR #1 did not eat breakfast or lunch aside from one cup of vanilla pudding. He stated he told the floor nurse but could not remember her name or if the floor nurse took action. During an interview on [DATE] at 12:59 p.m., the NP stated she did not receive a call directly on [DATE] because they have on call services where the providers in her group take turns answering. She stated that a BP reading of 86/57 or 89/59 was very concerning and staff nurses should not try to do anything without speaking to the doctor. She stated that if CR #1 had symptoms of not eating all day, tired, with low blood sugar, she would have sent him out to the emergency room. Additional questions were asked to the NP, but she refused to answer questions and stated she did not want to continue the interview with the surveyor. During an interview on [DATE] at 1:19 p.m., CNA E stated that she worked from 6:00 p.m. - 6:00 a.m. on [DATE]. She stated CR#1 was out of it on [DATE] and he barely said two words to her. She asked him if he was ok because he did not seem like himself because he slept the majority of her shift when he usually would stay up late and play on his computer. CNA E stated she communicated with LVN C about CR#1's condition and they checked on him several times throughout the night. CNA E stated she asked CR#1 if he was ok or if he needed water. CNA E stated CR#1 did not verbally communicate with her at all and only shook his head in (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	response to questions. She stated CR #1's eyes were closed when she spoke to him and his breathing seemed heavy. CNA E stated that it was strange that CR#1 slept the majority of the night because he normally would not go to sleep until her shift was over (around 6 a.m.). During an interview on [DATE] at 1:33 p.m., MA A stated she worked from 6:00 a.m.- 2:00 p.m. on [DATE]. MA A stated when she took CR#1's BP that morning, his BP read 113/74 and he was fine. He took his medication without refusals and nothing seemed out of the normal. She explained that if his BP was outside the parameters of 110-120 systolic and 70-85 diastolic (Systolic blood pressure (top number) measures the maximum force against artery walls when the heart beats (contracts). Diastolic blood pressure (bottom number) measures the minimum pressure in arteries as the heart rests between beats), she would hold his medicine and tell the nurse. During an interview on [DATE] at 1:51 p.m., MA B stated he worked on [DATE] from 2:00 p.m.- 10:00 p.m. MA B state CR#1's BP was low on [DATE] and he had to hold his BP medicine. He stated that he told the nurse (unknown) but could not say which nurse or what their name was. MA B stated the nurse had no response when he informed her, restating that he was not sure what she said, then stating he did not know. MA B stated that CR#1 was sleeping and a little quite on [DATE], but otherwise no problems. During an interview on [DATE] at 3:03 p.m., LVN B stated she worked from 6:00 a.m. - 6:00 p.m. on [DATE]. She stated she did not receive any notifications from the CNAs or MA who worked [DATE] that CR#1 had low blood pressure and had not eaten. She stated she was very upset because if she would have known she would have called his provider to see what needed to be done. She stated that a systolic of 86 was very low and stated, Why would they not say anything!During an interview on [DATE] at 5:03 p.m., LVN C stated that she worked from 6 p.m.- 6 a.m. on [DATE]. LVN C stated that she checked on him several times throughout the night and she asked him if he was ok, he would say yes or nod his head. He was a very chatty person, but he did not talk during the night so she did not notice a change in his behavior. She stated that CNA D told her that CR#1 had not eaten breakfast or lunch but he stated that he told LVN B about his behavior. She had no knowledge of low BP readings from MA B. If she had known he had a low BP, she stated she would have reached out to the provider immediately.During an interview on [DATE] at 10:31 a.m., the DON stated when MA B identified CR#1 had low blood pressure on [DATE], he should have notified the nurse immediately and staff had been educated previously on what to do when there was a change in condition with a resident. The DON stated CNAs and MAs were expected to provide verbal updates to the nurses and nurses would notify the provider of changes, complete the documentation, and she would oversee it. She explained the chain of command went from CNAs/MA, to nurse, and to herself. The DON stated that per the policy, the provider should be informed of all significant changes. Record review of the facility's policy titled, Change in Resident Condition, revised 01/2023, documented when there was significant change in the resident's physical, mental, or psychosocial status, the medical provider should be contacted.This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 1:47 p.m. The Administrator, DON, and ADON were notified. The Administrator and DON was provided with the IJ templated [DATE] at 1:47 p.m. The following Plan of Removal submitted by the facility was accepted on [DATE] at 10:00 a.m. It was documented as follows:F 580 Notify of ChangesThe facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).Situation: Resident # 1 was discharged to the hospital on [DATE]. Director of Clinical Operations/ Regional Nurse identified medication aide #1 and immediately removed medication aide #1 from his assignment pending receiving of in serviced training regarding Medication Administration, Reporting of Abnormal vital signs to his charge nurse, Abuse/Neglect and Residents Rights -conducted by Director of Clinical Operations/ Regional Date Completed: [DATE] Director of Clinical Operations/ Regional and Administrator counseled medication aide #1 and a performance written action completed r/t medication aide #1's failure to ensure proper reporting of the low blood pressure readings to his charge nurse on [DATE]. Certified medication aide #1. Conducted by Director of (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Clinical Operations/ Regional and Administrator.Director of Clinical Operations/ Regional Nurses provided immediate re- education to all licensed nurses on the following: The expected process for: 1. Immediately evaluating/assessing resident upon a suspected or identified change in condition is noted. 2. Documenting nursing findings to include but not limited to evaluation of vital signs and utilizing the appropriate Change in Condition User Defined Assessment and/or Nursing Progress Note to ensure proper documentation is noted within the medical record. 3. Nurse to promptly report the identified change in condition (exception of usual baseline status) to the Medical Provider in order to ensure appropriate interventions are provided and carried out as ordered/recommended. 4. Nurse to ensure that appropriate notification is made to the resident's representative. 5. The Nurse is expected to ensure that all appropriate documentation to reflect 1-4 are noted with the electronic health record. 6. The Nurse should review the vital sign form (vital signs taken by certified medication aide) to ensure that any abnormal vital signs have been reviewed by the nurse with appropriate re-assessment and interventions to include the licensed nurse conducting the evaluation/assessment, notification to the Medical Provider, carrying out any recommended or prescribed medical interventions and notification to the resident's representative promptly, and ensuring all is documented within the electronic health record. 7. The nurse will ensure that all identified changes in condition or suspected changes in condition will be reported to the on-coming nurse to ensure appropriate 24-hour reporting at change of shift as per usual hand-off process. *No nursing staff full-time, part-time, PRN or nursing staff on leave will work their next assigned shift until all in-service training is completed. Date of completion: [DATE] Director of Clinical Operations/ Regional Nurses educated all certified medication aides on Medication Administration: 8. Right resident, right route, right dose, right time, right medication and right documentation. 9. Certified Medication Aides will also notify the charge nurse immediately of any abnormal vital signs.Date completed: [DATE] Director of Clinical Operations/ Regional Nurses educated all team members on the Stop and Watch process. 10. Stop and Watch is noted within the platform of the electronic health record and/or paper form - this process is expected to be utilized by nursing team members upon identification in subtle changes that could be indicative of a change in the resident's condition. Changes may include but not limited to increased sleepiness, not eating, not eating as much, not getting up as usual, not participating in usual activities, minimal or decreased communication (when they usually communicate often) are some changes that will warrant a Stop and Watch process. 11. This process should be completed in PCC/EMR and/or on paper form should be communicated to the nurse and paper form should be turned into the charge nurse upon completion and prior to end of shift to ensure nurse has conducted appropriate follow up to include proper assessment to be conducted. 12. The nurse should turn a copy of the paper form to the Director of Nursing Services. 13. Additionally, all nursing team members are to notify the Director of Nursing upon a change of condition identified along with information regarding the Stop and Watch process has been completed, assessment conducted and notifications to the Medical Provider and Representative have been made this is expected to take place immediately but not to exceed end of shift. 14. Blank copies of the Stop and Watch form will be readily available at the nurse's station for use. 15. A copy of the Stop and Watch form will be placed in the Plan of Removal binder available for State surveyor's review. *No nursing staff full-time, part-time, PRN or nursing staff on leave will work their next assigned shift until all in-service training is completed. Date completed: [DATE] Director of Nursing Services/Assistant Director of Nursing Services completed a 100% audit on all residents in the community to identify any residents with a change in condition. Outcome: 2 of 123 active residents were noted with an identified change in condition. The resident was on end-of-life care (hospice care) and the other resident noted with an acute condition that occurred at the time the audit was being conducted. Nurses conducted appropriate assessments, communication with the Medical Provider, orders received, change in condition was documented within the electronic health record and appropriate notifications to RP were made and the nursing 24-hour communication report was updated (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	accordingly. Date completed: [DATE] Director of Clinical Operations/Director of Clinical Education provided education on Abuse/Neglect and Residents Rights to all nursing team members. Date of completion:[DATE]Community will ensure all nursing staff on leave/PRN nursing staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior to nursing team members working their next assigned shift. The facility will ensure all residents receive appropriate and immediate care after a change in condition.*No nursing staff full-time, part-time, PRN or nursing staff on leave will work their next assigned shift until all in-service training is completed. Risk Response:All residents who are currently reside in the community with a change in condition have the potential to be affected by the deficient practice.Systemic Response: Director of Clinical Operations/ Regional Nurses provided education to all licensed nurses on the following: The process to utilize immediately when a change in condition is noted. The Change in Condition User Defined Assessment is expected to be implemented in conjunction with an immediate assessment to include vital signs. This information will be immediately reported to the physician/NP so that interventions can be put in place to treat our patient. This will also include notifications to the party responsible for the resident. The Charge nurse will also complete a progress note to include documentation with notifications of the change in status to the MD/PCP and resident's representative accordingly. The Charge nurse will also review the Vital Sign form the certified medication aide will turn in at the end of the shift for review to the licensed nurse. The Charge nurse will review the vital sign form and address any abnormal vital signs. The Change in condition will be completed with a change in the resident's overall condition, after an assessment by the licensed nurse. All abnormal vital signs will warrant an assessment by the licensed nurse and notification to the physician/nurse practitioner and resident's representative, immediately. Date of completion: [DATE] Director of Clinical Operations/ Regional Nurses educated all certified medication aides on Medication Administration: Right resident, right route, right dose, right time, right medication and right documentation. Certified Medication Aides will also notify the charge nurse immediately of any abnormal vital signs. Certified Medication Aides will hand write all vital signs on the Vital sign form provided and turn into the charge nurse at the end of the shift. A copy of the Vital Sign form will be placed in the Abatement Plan Removal binder available for State surveyor's review. Date completed: [DATE] Director of Clinical Operations/ Regional Nurses educated all team members on the Stop and Watch process. This form will be used for all team members upon identification in a change in the resident's condition. Some of the changes may include increased sleepiness, not eating, not eating as much, not getting up as usual, minimal or decreased communication (when they usually communicate often) are some changes that will warrant a Stop and Watch form. This form will be completed and turned into the charge nurse. A copy of this form will be given to the Director of Nursing Services. In addition, all team members are to notify the Director of Nursing by phone when a Stop and Watch form is completed with notification of the change in condition, immediately. Blank copies of these forms will be available on the 600 hall on the wall in a secure compartment. Copies will also be at the nurse's station for access and use. A copy of the Stop and Watch form will be placed in the Abatement Plan Removal binder available for State surveyor's review. Date completed: [DATE] Director of Clinical Operations/ Regional Nurses completed a 100% audit on all residents in the community to identify any residents with a change in condition. Outcome: 2 of 123 active residents were noted with an identified change in condition. The resident was on end-of-life care (hospice care) and the other resident noted with an acute condition that occurred at the time the audit was being conducted. Nurses conducted appropriate assessments, communication with the Medical Provider, orders received, change in condition was documented within the electronic health record and appropriate notifications to RP were made and the nursing 24-hour communication report was updated accordingly. A copy of the change in condition forms will be placed in the binder for the incident and available for all state surveyors to review. Date completed: [DATE] Director of Clinical Operations/Regional Nurses provided immediate education on Abuse/Neglect and Residents Rights to (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	all nursing team members. Date of completion: [DATE]Community will ensure all nursing staff on leave/PRN nursing staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior to nursing team members working their assigned shift. The facility will ensure all residents receive appropriate and immediate care after a change in condition.*No nursing staff full-time, part-time, PRN or nursing staff on leave will work their next assigned shift until all in-service training is completed. Ad Hoc Meeting was conducted on [DATE] Administrator, Director of Nursing Services and Medical Director discussed addressing the immediacy issue regarding:F 580 Notify of Changes---The facility failed to consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications), and the plan of removal to lift the immediacy. Monitoring/Verification of Plan of removal: [DATE]Record review reflected that facility-wide in-services conducted between [DATE] and [DATE] were completed across all shifts. Staff were educated on abuse and neglect, including identification of abuse types such as neglect, exploitation, and misappropriation of property. Documentation reflected the Administrator was identified as the Abuse Coordinator.Record review reflected the facility's policy titled Notification of Change in Condition was reviewed with CNAs, CMAs, and nurses between [DATE] and [DATE].Record review that in-services was conducted on [DATE] and [DATE] under the direction of clinical leadership. The in-service reflected that the facility had implemented a Stop and Watch program utilized by all staff to report changes in resident conditions. Documentation indicated changes in condition included increased sleepiness, decreased appetite, decline in activity level, or deviation from baseline. Completed forms were submitted to the charge nurse, and the DON was to be notified immediately by phone for any identified change. Record review reflected that when a change in condition was identified, staff were expected to immediately assess the resident and document findings, including vital signs, change in condition assessments, and/or progress notes. Documentation indicated nurses were responsible for notifying the medical provider promptly and ensuring appropriate interventions were implemented. Nurses were also expected to review vital signs obtained by the medication aids for abnormalities and communicate all changes in condition during shift report to ensure continuity of care.Record review reflected that medication aides were educated on the five rights of medication administration (right patient, right medication, right dose, right time, and right documentation). Documentation indicated medication aides recorded vital signs on a designated log and submitted the documentation to the nurse daily.Record review reflected a conduct and workplace expectation notice issued to MA B for failure to follow protocol in notifying the charge nurse of a low blood pressure reading. Documentation indicated the staff member received verbal and written coaching and was re-educated on facility policy and procedures related to change in condition and notification requirements. Record review of the facility's Change in Condition audit tool reflected daily audits were conducted. Documentation dated [DATE] reflected four residents were reviewed, with compliance noted for all residents. Documentation indicated CIC forms were completed and corresponding progress notes were updated.Record review of the medication aide vital sign monitoring log reflected resident vital monitoring was completed daily from [DATE] through [DATE].Staff interviews:During interviews conducted on [DATE] between 1:14 p.m. and 3:18 p.m., LVN D, LVN E, and RN A, who worked the 6:00 a.m. - 6:00 p.m. and 8:00 a.m. - 5:00 p.m. shifts, stated they were in-serviced on abuse and neglect, including resident rights and the requirement to report allegations immediately to the Administrator, identified as the Abuse Coordinator. They reported that changes in condition were identified through assessment and staff reporting, followed by documentation in progress notes, completion of CIC assessments, and physician and family notification as applicable. Nurses indicated that CNAs and medication aides were expected to report changes immediately. Vital sign monitoring was reviewed for trends and Stop and Watch forms were maintained at the nurses' station and were utilized to communicate observed changes in resident (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	condition. During interviews conducted on [DATE] between 3:31 p.m. and 3:33 p.m., RN B, RN C, and LVN C who worked the 6:00 p.m. - 6:00 a.m. shift, reported abuse and neglect training included identification of various types of abuse and immediate reporting to the Administrator. Nurses stated that changes in condition were identified as deviations from baseline (altered mental status, abnormal vital signs) and required completion of CIC assessments, documentation in progress notes, and physician notification. Nurses indicated reliance on CNAs and medication aides to report changes promptly and confirmed review of vital sign documentation for abnormalities. On [DATE] between 3:41 p.m. and 3:47 p.m., attempts were made to interview LVN B (PRN) and LVN A. No responses were received, and voicemail messages were left for returned calls. Call attempts were also made by the DON but were unsuccessful. During interviews conducted on [DATE] between 1:26 p.m. and 3:10 p.m., CNAs F, G, H, I, J, K, and X, who worked the 6:00 a.m. - 2:00 p.m. and 6:00 a.m. - 6:00 p.m. shifts, stated they were trained on abuse and neglect, including resident rights and the requirement to report immediately to the Administrator. CNAs identified types of abuse as physical, verbal, mental, sexual, and neglect. They reported that Stop and Watch forms were used to document and communicate changes in condition such as decreased intake, altered behavior, lethargy, abnormal vital signs, or skin changes. CNAs stated they notified the nurse immediately upon identifying a change and submitted completed forms to the nurse and/or DON. During interviews conducted on [DATE] between 3:26 p.m. and 4:07 p.m., CNAs L, M, N, O, P who worked the 2:00 p.m. - 10:00 p.m. and 6:00 p.m. - 6:00 a.m. shifts, stated they were trained to report abuse and neglect immediately to the Administrator. CNAs described Stop and Watch forms as tools used to report any observed change in resident condition, including behavioral changes, decreased appetite, abnormal vital signs, or signs of distress. CNAs reported they notified the charge nurse immediately and provided completed forms to the nurse and DON, with some indicating additional notification (e.g., calling or texting the DON). During interviews conducted on [DATE] between 2:36 p.m. and 3:10 p.m., CNAs Q, R, S, T, and U, who worked 6:00 a.m. - 6:00 p.m., 2:00 p.m. - 10:00 p.m., and PRN shifts, reported abuse and neglect training included immediate reporting to the Administrator. CNAs stated Stop and Watch forms were used to document changes in condition such as decreased intake, altered communication, lethargy, or decline in functional status, and were submitted to the nurse and DON. CNAs consistently reported that changes in condition were to be communicated to the nurse immediately upon observation. During an interview conducted on [DATE] at 1:42 p.m., MA C, who worked the 6:00 a.m. - 2:00 p.m. shift, reported abuse and neglect training included resident rights and immediate reporting to the Administrator. MA C stated vital signs were recorded and communicated to the nurse, and any abnormal findings or changes in condition (e.g., unresponsiveness, abnormal vitals) were reported immediately. Stop and Watch forms were used to document and communicate observed changes. During interviews conducted on [DATE] between 2:23 p.m. and 3:04 p.m., MAs B, D, and E, who worked the 2:00 p.m. - 10:00 p.m. shift, stated abuse and neglect training included identifying and reporting abuse immediately to the Administrator and/or DON. MAs reported they documented vital signs and notified nurses of abnormalities or changes in condition. Stop and Watch forms were described as tools used to report changes such as altered intake, vital sign abnormalities, or decline in condition, and were submitted to the nurse and DON. During an interview conducted on [DATE] at 10:40 a.m., LVN A, who worked the 6:00 a.m. - 6:00 p.m. shift, stated the Stop and Watch process was used by CNAs and medication aides to report changes in resident condition, including abnormal vital signs, changes in cognition, weakness, or any deviation from baseline. LVN A stated staff were expected to report changes immediately, and the nurse would assess the resident, document findings, and notify the physician or nurse practitioner as needed. She reported vital signs were reviewed daily and provided by medication aids. The Administrator and DON were informed the Immediate Jeopardy was removed on [DATE] at 7:14 p.m. The facility remained out of compliance at a severity level of minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective syst[TRUNCATED]

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	676153	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of League City	2620 W Walker League City, TX 77573

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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 - Immediate jeopardy to resident health or safety 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 that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (CR#1) of 4 residents reviewed for quality care. 1. MA B and CNA B failed to notify LVN B and LVN C on [DATE] when CR#1 refused all meals, had increased drowsiness, and had hypotensive BP readings of 89/59 at 2:31 p.m. and 86/57 at 7:08 p.m. In result, LVN's failed to seek medical guidance from CR #1's physician related to the change in condition until 8:30 am on [DATE] when he became unresponsive and was sent out via EMT.2. CR#1 required several rounds of CPR and was diagnosed with a blood infection, septic shock, and suffered an acute stroke.On [DATE] at 1:47 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on [DATE], the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated and due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition and/or infection, stroke, or death. Findings included:Record review of CR#1's face sheet, dated [DATE], documented a [AGE] year-old male, admitted [DATE]. His admitting diagnoses were Type 2 Diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), presence of cardiac implants and grafts (cardiovascular surgery where artificial devices were inserted), morbid severe obesity due to excess calories, hypertension (high blood pressure), cerebral infarction (stroke), and he was a full code (a medical directive indicating that in the event of a cardiac or respiratory arrest, all possible life-saving interventions)Record review of CR#1's care plan, dated [DATE], documented CR#1 had chronic health issues and comorbid conditions that may further affect his quality of life. Interventions stated to monitor vital signs and report all changes in condition to a doctor.Record review of CR#1's vital signs on [DATE], MA B documented CR#1's BP was 89/59 at 2:31 p.m. and 86/57 at 7:08 p.m. Record review of CR#1's CIC assessments documented no CIC assessment completed on [DATE].Record review of CR#1's progress note dated [DATE] at 10:53 a.m. created by LVN A, revealed that upon entering CR#1's room, he appeared asleep with minimal communication. CR#1 did not attempt to eat breakfast, he was barely responsive, and clammy to touch. Record review further revealed LVN A noted CR#1's BP to be low at 75/54 and he was unresponsive to a sternal rub. Record review revealed the resident was sent out due to an acute change in condition, hypotension (abnormally low blood pressure below 90/60 that indicates blood if not flowing adequately to the organs), increased work in breathing, and unresponsiveness. EMS was called, provider (a licensed person or organization that provides health care services such as doctor or NP) notified, DON notified, and family made aware of discharge.During an interview on [DATE] at 9:05 a.m., the PMD stated CR#1 was found unresponsive to a hard sternal rub (an emergency medical technique used to assess a patient's responsiveness by applying firm, grinding pressure with knuckles to the center of the chest or sternum) and his BP reading was low. The PMD stated CR#1 had vomit around his mouth and he looked like he had been deteriorating for hours. He stated that CR#1 technically passed away twice in the hospital but he was resuscitated.During an observation and interview on [DATE] at 9:35 a.m., CR#1 was seen intubated in the ICU. He could not open his eyes, but he raised his eyebrows when his name was called. The HRN stated CR#1 was admitted due to unresponsiveness and they had to do three rounds of CPR because his heart stopped. On [DATE], CT (an imaging test that helps healthcare providers detect diseases and injuries) and MRI (a medical imaging technique used in radiology to generate pictures of the anatomy and the physiological processes inside the body) scans results showed that he had an infarct (presence indicates a disruption in blood flow to the brain, leading to cell death). The HRN stated cultures were also taken and results showed that he had an infection in the blood. The HRN stated CR #1 was currently (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	sedated but was responsive to pain, tried to open his eyes to speech, and his pupils reacted to light. The FM, who was in the room, stated CR #1 wiggled his toes the day before. During an interview on [DATE] with HNP at 10:02 a.m., she stated that CR#1's hospital documentation revealed that he was found positive for a blood infection (still awaiting detailed results), septic shock, mucus in his lungs, and CT scans revealed he suffered an acute stroke. When they checked his blood sugar, it was 63 and the normal range should be above 70. The HNP stated she could not state which diagnosis was responsible for his unresponsiveness, but stated it was caused by many factors. During an interview on [DATE] at 10:06 a.m., CR#1's FM stated CR#1 suffered a stroke over a year ago that affected his mobility but his mind was very sharp. She stated she was grateful LVN A went back to check on him inside his room at the nursing facility and stated, LVN A probably saved CR#1's life. During an interview on [DATE] at 12:17 p.m., LVN A stated that she worked on [DATE] from 6:00 a.m.- 6:0 p.m. LVN A stated that when she arrived on shift LVN C informed her that CR#1 slept throughout the night and he would respond that he was ok but seemed really tired. LVN A stated when she on CR #1, she knew something was different because he was usually alert and oriented x3-4 (alert and oriented to person, place, time, and situation) and he was able to communicate his needs but he was drowsy and barely spoke. She stated his breakfast tray was untouched and that was unlike him. LVN A stated a medication aide and LVN A agreed CR #1 looked clammy, BP was low, and his blood sugar was 77. LVN A stated 911 was called and he was still unresponsive upon arrival of EMT. LVN A stated EMT replaced his CPAP (keeps your airways open while you sleep so you can receive the oxygen you need) with a non-rebreather mask (used for patients needing high-flow oxygen, such as in severe respiratory distress, trauma, or emergencies) and CR #1 was taken to the hospital. During an interview on [DATE] at 12:23 p.m., CNA D stated he worked from 6:00 a.m.- 2:00 p.m. on [DATE]. He stated CR#1 normally liked to play on his computer but he did not play on it on [DATE] and slept the majority of the day. CNA D described CR#1 as very sleepy and stated CR #1 did not eat breakfast or lunch aside from one cup of vanilla pudding. He stated he told the floor nurse but could not remember her name or if the floor nurse took action. During an interview on [DATE] at 12:59 p.m., the NP stated she did not receive a call directly on [DATE] because they have on call services where the providers in her group take turns answering. She stated that a BP reading of 86/57 or 89/59 was very concerning and staff nurses should not try to do anything without speaking to the doctor. She stated that if CR #1 had symptoms of not eating all day, tired, with low blood sugar, she would have sent him out to the emergency room. Additional questions were asked to the NP, but she refused to answer questions and stated she did not want to continue the interview with the surveyor. During an interview on [DATE] at 1:19 p.m., CNA E stated that she worked from 6:00 p.m. - 6:00 a.m. on [DATE]. She stated CR#1 was out of it on [DATE] and he barely said two words to her. She asked him if he was ok because he did not seem like himself because he slept the majority of her shift when he usually would stay up late and play on his computer. CNA E stated she communicated with LVN C about CR#1's condition and they checked on him several times throughout the night. CNA E stated she asked CR#1 if he was ok or if he needed water. CNA E stated CR#1 did not verbally communicate with her at all and only shook his head in response to questions. She stated CR #1's eyes were closed when she spoke to him and his breathing seemed heavy. CNA E stated that it was strange that CR#1 slept the majority of the night because he normally would not go to sleep until her shift was over (around 6 a.m.). During an interview on [DATE] at 1:33 p.m., MA A stated she worked from 6:00 a.m.- 2:00 p.m. on [DATE]. MA A stated when she took CR#1's BP that morning, his BP read 113/74 and he was fine. He took his medication without refusals and nothing seemed out of the normal. She explained that if his BP was outside the parameters of 110-120 systolic and 70-85 diastolic (Systolic blood pressure (top number) measures the maximum force against artery walls when the heart beats (contracts). Diastolic blood pressure (bottom number) measures the minimum pressure in arteries as the heart rests between beats), she would hold his medicine and tell the nurse. During an interview on [DATE] at 1:51 p.m., MA B stated he worked on [DATE] from 2:00 p.m.- 10:00 p.m. MA B state (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CR#1's BP was low on [DATE] and he had to hold his BP medicine. He stated that he told the nurse (unknown) but could not say which nurse or what their name was. MA B stated the nurse had no response when he informed her, restating that he was not sure what she said, then stating he did not know. MA B stated that CR#1 was sleeping and a little quite on [DATE], but otherwise no problems. During an interview on [DATE] at 3:03 p.m., LVN B stated she worked from 6:00 a.m. - 6:00 p.m. on [DATE]. She stated she did not receive any notifications from the CNAs or MA who worked [DATE] that CR#1 had low blood pressure and had not eaten. She stated she was very upset because if she would have known she would have called his provider to see what needed to be done. She stated that a systolic of 86 was very low and stated, Why would they not say anything!During an interview on [DATE] at 5:03 p.m., LVN C stated that she worked from 6 p.m.- 6 a.m. on [DATE]. LVN C stated that she checked on him several times throughout the night and she asked him if he was ok, he would say yes or nod his head. He was a very chatty person, but he did not talk during the night so she did not notice a change in his behavior. She stated that CNA D told her that CR#1 had not eaten breakfast or lunch but he stated that he told LVN B about his behavior. She had no knowledge of low BP readings from MA B. If she had known he had a low BP, she stated she would have reached out to the provider immediately.During an interview on [DATE] at 10:31 a.m., the DON stated when MA B identified CR#1 had low blood pressure on [DATE], he should have notified the nurse immediately and staff had been educated previously on what to do when there was a change in condition with a resident. The DON stated CNAs and MAs were expected to provide verbal updates to the nurses and nurses would notify the provider of changes, complete the documentation, and she would oversee it. She explained the chain of command went from CNAs/MA, to nurse, and to herself. The DON stated that per the policy, the provider should be informed of all significant changes. Record review of the facility's policy titled, Change in Resident Condition, revised 01/2023, documented when there was significant change in the resident's physical, mental, or psychosocial status, the medical provider should be contacted.This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 1:47 p.m. The Administrator, DON, and ADON were notified. The Administrator and DON was provided with the IJ templated [DATE] at 1:47 p.m. The following Plan of Removal submitted by the facility was accepted on [DATE] at 10:00 a.m. It was documented as follows:F 684 Quality of CareThe facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, in that:Situation: Resident # 1 was discharged to the hospital on [DATE]. Director of Clinical Operations/ Regional Nurse identified medication aide #1 and immediately removed medication aide #1 from his assignment pending receiving of in serviced training regarding Medication Administration, Reporting of Abnormal vital signs to his charge nurse, Abuse/Neglect and Residents Rights -conducted by Director of Clinical Operations/ Regional Date Completed: [DATE] Director of Clinical Operations/ Regional and Administrator counseled medication aide #1 and a performance written action completed r/t medication aide #1's failure to ensure proper reporting of the low blood pressure readings to his charge nurse on [DATE]. Certified medication aide #1. Conducted by Director of Clinical Operations/ Regional and Administrator.Director of Clinical Operations/ Regional Nurses provided immediate re-education to all licensed nurses on the following: The expected process for: 1. Immediately evaluating/assessing resident upon a suspected or identified change in condition is noted. 2. Documenting nursing findings to include but not limited to evaluation of vital signs and utilizing the appropriate Change in Condition User Defined Assessment and/or Nursing Progress Note to ensure proper documentation is noted within the medical record. 3. Nurse to promptly report the identified change in condition (exception of usual baseline status) to the Medical Provider in order to ensure appropriate interventions are provided and carried out as ordered/recommended. 4. Nurse to ensure that appropriate notification is made to the resident's representative. 5. The Nurse is expected to ensure that all appropriate documentation to reflect 1-4 are noted with the electronic health record. 6. The Nurse should review the vital sign form (vital signs taken by certified medication aide) to ensure (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that any abnormal vital signs have been reviewed by the nurse with appropriate re-assessment and interventions to include the licensed nurse conducting the evaluation/assessment, notification to the Medical Provider, carrying out any recommended or prescribed medical interventions and notification to the resident's representative promptly, and ensuring all is documented within the electronic health record. 7. The nurse will ensure that all identified changes in condition or suspected changes in condition will be reported to the on-coming nurse to ensure appropriate 24-hour reporting at change of shift as per usual hand-off process. *No nursing staff full-time, part-time, PRN or nursing staff on leave will work their next assigned shift until all in-service training is completed. Date of completion: [DATE] Director of Clinical Operations/ Regional Nurses educated all certified medication aides on Medication Administration: 8. Right resident, right route, right dose, right time, right medication and right documentation. 9. Certified Medication Aides will also notify the charge nurse immediately of any abnormal vital signs.Date completed: [DATE] Director of Clinical Operations/ Regional Nurses educated all team members on the Stop and Watch process. 10. Stop and Watch is noted within the platform of the electronic health record and/or paper form - this process is expected to be utilized by nursing team members upon identification in subtle changes that could be indicative of a change in the resident's condition. Changes may include but not limited to increased sleepiness, not eating, not eating as much, not getting up as usual, not participating in usual activities, minimal or decreased communication (when they usually communicate often) are some changes that will warrant a Stop and Watch process. 11. This process should be completed in PCC/EMR and/or on paper form should be communicated to the nurse and paper form should be turned into the charge nurse upon completion and prior to end of shift to ensure nurse has conducted appropriate follow up to include proper assessment to be conducted. 12. The nurse should turn a copy of the paper form to the Director of Nursing Services. 13. Additionally, all nursing team members are to notify the Director of Nursing upon a change of condition identified along with information regarding the Stop and Watch process has been completed, assessment conducted and notifications to the Medical Provider and Representative have been made this is expected to take place immediately but not to exceed end of shift. 14. Blank copies of the Stop and Watch form will be readily available at the nurse's station for use. 15. A copy of the Stop and Watch form will be placed in the Plan of Removal binder available for State surveyor's review. *No nursing staff full-time, part-time, PRN or nursing staff on leave will work their next assigned shift until all in-service training is completed. Date completed: [DATE] Director of Nursing Services/Assistant Director of Nursing Services completed a 100% audit on all residents in the community to identify any residents with a change in condition. Outcome: 2 of 123 active residents were noted with an identified change in condition. The resident was on end-of-life care (hospice care) and the other resident noted with an acute condition that occurred at the time the audit was being conducted. Nurses conducted appropriate assessments, communication with the Medical Provider, orders received, change in condition was documented within the electronic health record and appropriate notifications to RP were made and the nursing 24-hour communication report was updated accordingly. Date completed: [DATE] Director of Clinical Operations/Director of Clinical Education provided education on Abuse/Neglect and Residents Rights to all nursing team members. Date of completion:[DATE]Community will ensure all nursing staff on leave/PRN nursing staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior to nursing team members working their next assigned shift. The facility will ensure all residents receive appropriate and immediate care after a change in condition.*No nursing staff full-time, part-time, PRN or nursing staff on leave will work their next assigned shift until all in-service training is completed. Risk Response:All residents who are currently reside in the community with a change in condition have the potential to be affected by the deficient practice.Systemic Response: Director of Clinical Operations/ Regional Nurses provided education to all licensed nurses on the following: The process to utilize immediately when a change in condition is noted. The Change in Condition User Defined Assessment is expected to be implemented in (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	conjunction with an immediate assessment to include vital signs. This information will be immediately reported to the physician/NP so that interventions can be put in place to treat our patient. This will also include notifications to the party responsible for the resident. The Charge nurse will also complete a progress note to include documentation with notifications of the change in status to the MD/PCP and resident's representative accordingly. The Charge nurse will also review the Vital Sign form the certified medication aide will turn in at the end of the shift for review to the licensed nurse. The Charge nurse will review the vital sign form and address any abnormal vital signs. The Change in condition will be completed with a change in the resident's overall condition, after an assessment by the licensed nurse. All abnormal vital signs will warrant an assessment by the licensed nurse and notification to the physician/nurse practitioner and resident's representative, immediately. Date of completion: [DATE] Director of Clinical Operations/ Regional Nurses educated all certified medication aides on Medication Administration: Right resident, right route, right dose, right time, right medication and right documentation. Certified Medication Aides will also notify the charge nurse immediately of any abnormal vital signs. Certified Medication Aides will hand write all vital signs on the Vital sign form provided and turn into the charge nurse at the end of the shift. A copy of the Vital Sign form will be placed in the Abatement Plan Removal binder available for State surveyor's review. Date completed: [DATE] Director of Clinical Operations/ Regional Nurses educated all team members on the Stop and Watch process. This form will be used for all team members upon identification in a change in the resident's condition. Some of the changes may include increased sleepiness, not eating, not eating as much, not getting up as usual, minimal or decreased communication (when they usually communicate often) are some changes that will warrant a Stop and Watch form. This form will be completed and turned into the charge nurse. A copy of this form will be given to the Director of Nursing Services. In addition, all team members are to notify the Director of Nursing by phone when a Stop and Watch form is completed with notification of the change in condition, immediately. Blank copies of these forms will be available on the 600 hall on the wall in a secure compartment. Copies will also be at the nurse's station for access and use. A copy of the Stop and Watch form will be placed in the Abatement Plan Removal binder available for State surveyor's review. Date completed: [DATE] Director of Clinical Operations/ Regional Nurses completed a 100% audit on all residents in the community to identify any residents with a change in condition. Outcome: 2 of 123 active residents were noted with an identified change in condition. The resident was on end-of-life care (hospice care) and the other resident noted with an acute condition that occurred at the time the audit was being conducted. Nurses conducted appropriate assessments, communication with the Medical Provider, orders received, change in condition was documented within the electronic health record and appropriate notifications to RP were made and the nursing 24-hour communication report was updated accordingly. A copy of the change in condition forms will be placed in the binder for the incident and available for all state surveyors to review. Date completed: [DATE] Director of Clinical Operations/Regional Nurses provided immediate education on Abuse/Neglect and Residents Rights to all nursing team members. Date of completion: [DATE]Community will ensure all nursing staff on leave/PRN nursing staff are in serviced prior to working their shift. Community will ensure administrative nursing staff in the community to provide in-service/education prior to nursing team members working their assigned shift. The facility will ensure all residents receive appropriate and immediate care after a change in condition.*No nursing staff full-time, part-time, PRN or nursing staff on leave will work their next assigned shift until all in-service training is completed. Ad Hoc Meeting was conducted on [DATE] Administrator, Director of Nursing Services and Medical Director discussed addressing the immediacy issue regarding:F 684 Quality of Care-- The facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. and the plan of removal to lift the immediacy. Monitoring/Verification of Plan of removal: [DATE]Record review reflected that facility-wide in-services conducted between [DATE] and [DATE] were completed (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	across all shifts. Staff were educated on abuse and neglect, including identification of abuse types such as neglect, exploitation, and misappropriation of property. Documentation reflected the Administrator was identified as the Abuse Coordinator.Record review reflected the facility's policy titled Notification of Change in Condition was reviewed with CNAs, CMAs, and nurses between [DATE] and [DATE].Record review that in-services was conducted on [DATE] and [DATE] under the direction of clinical leadership. The in-service reflected that the facility had implemented a Stop and Watch program utilized by all staff to report changes in resident conditions. Documentation indicated changes in condition included increased sleepiness, decreased appetite, decline in activity level, or deviation from baseline. Completed forms were submitted to the charge nurse, and the DON was to be notified immediately by phone for any identified change. Record review reflected that when a change in condition was identified, staff were expected to immediately assess the resident and document findings, including vital signs, change in condition assessments, and/or progress notes. Documentation indicated nurses were responsible for notifying the medical provider promptly and ensuring appropriate interventions were implemented. Nurses were also expected to review vital signs obtained by the medication aids for abnormalities and communicate all changes in condition during shift report to ensure continuity of care.Record review reflected that medication aides were educated on the five rights of medication administration (right patient, right medication, right dose, right time, and right documentation). Documentation indicated medication aides recorded vital signs on a designated log and submitted the documentation to the nurse daily.Record review reflected a conduct and workplace expectation notice issued to MA B for failure to follow protocol in notifying the charge nurse of a low blood pressure reading. Documentation indicated the staff member received verbal and written coaching and was re-educated on facility policy and procedures related to change in condition and notification requirements. Record review of the facility's Change in Condition audit tool reflected daily audits were conducted. Documentation dated [DATE] reflected four residents were reviewed, with compliance noted for all residents. Documentation indicated CIC forms were completed and corresponding progress notes were updated.Record review of the medication aide vital sign monitoring log reflected resident vital monitoring was completed daily from [DATE] through [DATE].Staff interviews:During interviews conducted on [DATE] between 1:14 p.m. and 3:18 p.m., LVN D, LVN E, and RN A, who worked the 6:00 a.m. - 6:00 p.m. and 8:00 a.m. - 5:00 p.m. shifts, stated they were in-serviced on abuse and neglect, including resident rights and the requirement to report allegations immediately to the Administrator, identified as the Abuse Coordinator. They reported that changes in condition were identified through assessment and staff reporting, followed by documentation in progress notes, completion of CIC assessments, and physician and family notification as applicable. Nurses indicated that CNAs and medication aides were expected to report changes immediately. Vital sign monitoring was reviewed for trends and Stop and Watch forms were maintained at the nurses' station and were utilized to communicate observed changes in resident condition. During interviews conducted on [DATE] between 3:31 p.m. and 3:33 p.m., RN B, RN C, and LVN C who worked the 6:00 p.m. - 6:00 a.m. shift, reported abuse and neglect training included identification of various types of abuse and immediate reporting to the Administrator. Nurses stated that changes in condition were identified as deviations from baseline (altered mental status, abnormal vital signs) and required completion of CIC assessments, documentation in progress notes, and physician notification. Nurses indicated reliance on CNAs and medication aides to report changes promptly and confirmed review of vital sign documentation for abnormalities. On [DATE] between 3:41 p.m. and 3:47 p.m., attempts were made to interview LVN B (PRN) and LVN A. No responses were received, and voicemail messages were left for returned calls. Call attempts were also made by the DON but were unsuccessful. During interviews conducted on [DATE] between 1:26 p.m. and 3:10 p.m., CNAs F, G, H, I, J, K, and X, who worked the 6:00 a.m. - 2:00 p.m. and 6:00 a.m. - 6:00 p.m. shifts, stated they were trained on abuse and neglect, including resident rights and the requirement to report immediately to the Administrator. CNAs identified types of abuse as physical, verbal, mental, sexual, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676153	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of League City	2620 W Walker League City, TX 77573

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	and neglect. They reported that Stop and Watch forms were used to document and communicate changes in condition such as decreased intake, altered behavior, lethargy, abnormal vital signs, or skin changes. CNAs stated they notified the nurse immediately upon identifying a change and submitted completed forms to the nurse and/or DON. During interviews conducted on [DATE] between 3:26 p.m. and 4:07 p.m., CNAs L, M, N, O, P who worked the 2:00 p.m. - 10:00 p.m. and 6:00 p.m. - 6:00 a.m. shifts, stated they were trained to report abuse and neglect immediately to the Administrator. CNAs described Stop and Watch forms as tools used to report any observed change in resident condition, including behavioral changes, decreased appetite, abnormal vital signs, or signs of distress. CNAs reported they notified the charge nurse immediately and provided completed forms to the nurse and DON, with some indicating additional notification (e.g., calling or texting the DON). During interviews conducted on [DATE] between 2:36 p.m. and 3:10 p.m., CNAs Q, R, S, T, and U, who worked 6:00 a.m. - 6:00 p.m., 2:00 p.m. - 10:00 p.m., and PRN shifts, reported abuse and neglect training included immediate reporting to the Administrator. CNAs stated Stop and Watch forms were used to document changes in condition such as decreased intake, altered communication, lethargy, or decline in functional status, and were submitted to the nurse and DON. CNAs consistently reported that changes in condition were to be communicated to the nurse immediately upon observation. During an interview conducted on [DATE] at 1:42 p.m., MA C, who worked the 6:00 a.m. - 2:00 p.m. shift, reported abuse and neglect training included resident rights and immediate reporting to the Administrator. MA C stated vital signs were recorded and communicated to the nurse, and any abnormal findings or changes in condition (e.g., unresponsiveness, abnormal vitals) were reported immediately. Stop and Watch forms were used to document and communicate observed changes. During interviews conducted on [DATE] between 2:23 p.m. and 3:04 p.m., MAs B, D, and E, who worked the 2:00 p.m. - 10:00 p.m. shift, stated abuse and neglect training included identifying and reporting abuse immediately to the Administrator and/or DON. MAs reported they documented vital signs and notified nurses of abnormalities or changes in condition. Stop and Watch forms were described as tools used to report changes such as altered intake, vital sign abnormalities, or decline in condition, and were submitted to the nurse and DON. During an interview conducted on [DATE] at 10:40 a.m., LVN A, who worked the 6:00 a.m. - 6:00 p.m. shift, stated the Stop and Watch process was used by CNAs and medication aides to report changes in resident condition, including abnormal vital signs, changes in cognition, weakness, or any deviation from baseline. LVN A stated staff were expected to report changes immediately, and the nurse would assess the resident, document findings, and notify the physician or nurse practitioner as needed. She reported vital signs were reviewed daily and provided by medication aids. The Administrator and DON were informed the Immediate Jeopardy was removed on [DATE] at 7:14 p.m. The facility remained out of compliance at a severity level of minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.