

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Kingwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23775 Kingwood Place Kingwood, TX 77339	
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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that residents who required colostomy, urostomy, or ileostomy services, received such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one of three residents (Resident #2) reviewed for quality of care. The facility failed to ensure adequate and consistent colostomy care was provided every 3 days. Resident #2 went 6 days without her colostomy bag being changed. This failure could place residents at risk of physical and mental health decline and could cause pain and further discomfort. Findings include: Record review of Resident #2's face sheet, dated 07/22/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her admitting diagnoses included dementia (persistent loss of intellectual functioning), paraplegia (paralysis of the legs and lower body), type 2 diabetes mellitus (high blood sugar), morbid (severe) obesity due to excess calories, colostomy status (a surgical opening in the colon for the abdomen), urogenital implants (surgical device to assist in the function of urinary tract), unspecified convulsions (seizures), neuromuscular dysfunction of bladder (nerve and muscles that control the bladder muscle does not function properly), insomnia (hard to fall asleep), pressure ulcer of left buttock/Stage 4, carrier of carbapenem-resistant <i>Acinetobacter baumannii</i> (antibiotic resistance genes that allow the bacteria to make enzymes), overactive bladder (sudden need to urinate), vitamin D deficiency (lack of vitamin D in the body), chronic pain syndrome, chronic embolism and thrombosis (blood clot) (forms or persists in the large vein that carries deoxygenated blood from the lower body to the heart) of inferior vena cava (major veins of the body), gastroparesis (muscles in the stomach do not move food as they should) and bacterial infection (single-celled microorganisms, enter the body and grow uncontrollably or produce toxins that damage tissues). Record review of Resident #2's Annual MDS, dated [DATE], revealed she had a BIMS score of 11, which indicated moderate cognitive impairment. Resident #2 ambulated with a wheelchair and was dependent on staff for toileting hygiene, lower body dressing, putting on/taking off footwear and required substantial/maximal assistance for shower/bathe self, upper body dressing, and personal hygiene. Resident #2 was also dependent on staff for roll left and right, sit to lying, lying to sitting on side of bed, chair/bed-to-chair transfer, tub/shower and sit to stand and walk 10 feet did not occur. Resident #2 had an indwelling catheter and ostomy. Record review of Resident #2's Care Plan, dated 6/2/26, revealed Resident #2 had a colostomy at LLQ, dated 1/3/25, and she was to have adequate emptying of bowels daily and evidence any signs or symptoms of obstruction or constipation. The interventions were to monitor bowel output daily, nursing staff would change colostomy bag as needed, provide stoma care daily as instructed and PRN and report any abnormalities to the MD, LPN and RP. Record review of Resident #2's Orders, as of 7/22/26, revealed: Colostomy to LLQ as needed (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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change colostomy bag and wafer as needed, dated 5/27/25. Colostomy to LLQ every day shift every 3 days (s) change colostomy bag and wafer every 3 days, dated 5/28/25. Colostomy to LLQ every shift colostomy care Q shift and PRN use stoma paste and/or powder around the ostomy, dated 5/27/25. Enhanced suprapubic catheter every shift with high-contact care activities, dated 6/5/25. Record review of Resident #2's MAR revealed: Colostomy to LLQ every day shift every 3 day(s) change colostomy bag and wafer every 3 days order, dated 5/27/25 on 7/19/26 it was signed by LVN C. Record review of Resident #2's Progress notes did not reveal the Colostomy bag was changed on 7/17/26, 7/18/26, 7/19/26, 7/20/26 or 7/21/26. In an interview on 7/22/26 at 8:50 AM with Resident #2, she stated some of the staff took care of her colostomy bag and some of them did not. Resident #2 stated some if the CNA's didn't know how to let the air out of the colostomy bag. Resident #2 stated the staff changed her colostomy bag today. Resident #2 explained she had the same colostomy bag on for 6 days because the nurse on the 2 to 10 PM shift forgot. She stated the colostomy bag was just changed this morning. Resident #2 stated the colostomy bag was usually changed every 3 days by the nurse. Resident #2 said there was a lot of redness and blood sometime and the skin around the colostomy was really sore and it was because they had not been changing the colostomy bag. She stated the CNA's should be trained to at least burp the colostomy (let the gas out), but they went to get the nurse. Resident #2 stated her colostomy lasted 6 days and she mentioned that it needed to be changed. In an interview on 7/22/26 at 9:10 AM with LVN B, she stated Resident #2 was alert and oriented times 4 and she had a colostomy bag. LVN B stated she changed Resident #1's colostomy bag this morning, 7/22/26 and Resident #2 told her the colostomy was not changed for 6 days. LVN B stated the CNA's were able to burp the colostomy bags, but not change it. LVN B stated she told the night nurse. LVN B stated the colostomy should be changed at least every 3 days. She stated if the bag was in tack and her skin was good it was alright. LVN B stated it was Resident #2's preference to have it changed more often. LVN B stated the protocol for Resident #2 was 3 days. In an interview on 7/22/26 at 10:27 AM with RN A, she stated she was the weekend supervisor, but she did not work the halls. RN A stated colostomy bags should be changed every 3 days or when they were full. In an interview on 7/22/26 at 10:59 AM with CNA C, she stated she provided care for Resident #2 and she was alert and oriented times 4 (patient was fully aware of their Person, Place, Time, and Situation, indicating normal cognitive function and mental awareness) and she checked Resident #2's colostomy and emptied the colostomy bag and burped it. CNA C stated she worked with Resident #2 yesterday, 7/21/26, and the nurse was LVN D yesterday, 7/21/26. CNA C stated Resident #2 mentioned her colostomy bag had not been changed today, 7/22/26 and she told the nurse and that was why LVN B changed it. CNA C stated she had been burping Resident #2's colostomy bag, but it was the nurses responsibility to keep up with the colostomy bag and the days to make sure it was changed. In an interview on 7/22/26 at 12:10 PM with CNA A, she stated anytime Resident #2 had gas in the colostomy bag they burp it, and if it needed to be emptied, they emptied it. In an interview on 7/23/26 at 10:10 AM, LVN E stated she had only worked at the facility two times on 7/15/26, Wednesday on the (200 Hall) and 7/16/26, Thursday on the 400 and 600 hall. LVN E stated she was PRN. She stated on Wednesday, 7/15/26, the night shift nurse LVN F gave report. LVN E stated she did not recall anything with Resident #2's colostomy. She stated she checked Resident #2's foley, colostomy, blood pressure and blood sugar. She stated Resident #2's colostomy had not been emptied, so she emptied it, and there was residue on the bag, but the bag was flat. LVN E stated the night shift nurse (LVN F) said Resident #2 called her in there a few times for the colostomy. In an interview on 7/23/26 at 11:10 AM with CNA E, she stated she worked the 200 hall most of the time. CNA E stated she worked on 7/17/26, and 7/18/26, and 7/20/26. CNA E stated she worked with Resident #2 sometimes, but (continued on next page)		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she worked the back. CNA E stated she answered Resident #2's call light a lot, even when she did not have Resident #2, she helped her. CNA E stated she was her CNA on 7/20/26. She stated she did not recall noticing if the colostomy bag had been changed or not. She stated Resident #2 had an agency nurse. In an attempted interview on 7/23/26 at 11:33 AM with LVN D, there was no answer and a message could not be left. In an interview on 7/23/26 at 11:35 AM with CNA D, she stated she worked on 7/17/26 Friday, Saturday 7/18/26 and Sunday, 7/19/26 and she answered Resident #2's call light and emptied her colostomy bags. She remembered one day and it was all clear and no bowel movement in it but she did not remember what day it was. CNA D stated every time she went in there it always had BM. She needed to be burped. CNA D stated there was an agency nurse and one time the agency nurse had to leave. In a telephone interview on 7/23/26 at 11:43 AM with LVN C, she stated she was an Agency nurse and she did recall Resident #2. LVN C stated she had to empty her colostomy a few times, and there were no problems. LVN C stated one of the CNA's did not want to empty the colostomy. LVN C stated she was there Saturday, 7/18/26 and Sunday, 7/19/26. LVN C stated she never changed Resident #2's colostomy bag. LVN C stated she received report LVN D changed Resident #2's colostomy on 7/17/26. In an interview on 7/23/26 at 12:14 PM with CNA F she stated she just started working at the facility on 7/2/26. CNA F stated she emptied Resident#2's colostomy bag when asked. She stated there was an agency nurse (LVN D) who changed the colostomy bag. CNA F stated the nurses usually changed the colostomy bag at 5 AM before she went in. CNA F stated she did not see LVN D change the colostomy bag, but she told her she changed it at 5 AM on that morning. CNA F stated Resident #2 called her when it needed to be burped. CNA F stated the colostomy bag was full when she went in. She stated another CNA emptied it before and CNA F stated she emptied it again and put the clamp back on it. CNA F stated on Sunday 7/19/26, she never saw the colostomy bag that full before. CNA F stated she worked Friday 7/17/26, Saturday 7/18/26 and Sunday 7/19/26. CNA F stated the CNA's just emptied and burped the colostomy bag according to her training. In an interview on 7/23/26 at 12:28 PM with the NP, she stated if the colostomy bag was not changed it was not sterile. The NP stated the facility gave Resident #2 a new bag every 3 days and she could get a new bag if she needed it more often. The NP stated the colostomy was a dirty site, and the colostomy bag could become softer and leak more. The NP stated the stoma was not bleeding because of the bag, but it could make the skin burn if not changed. The NP stated the colostomy had two parts and if the colostomy bag was leaking it could burn the skin because it was acid. The NP stated it should have been changed twice in 6 days. In an interview on 7/23/26 at 2:00 PM with the DON, she stated it was important to follow the physician orders. She stated the colostomy order was to change the colostomy bag every 3 days, but it depended on the bags. The DON stated Resident #2 produced a lot of gas. In an interview on 7/23/26 at 2:44 PM with Administrator B, she stated she always instructed her staff to document that Administration was done, but they were not to sign for any other staff. She stated she would have the nurse come in and sign and EMAR. Administrator B stated if Resident #2 did not have her colostomy bag changed there would be a danger of discomfort. Record review of the facility policy, dated 12/2024 and revised on 4/2025, revealed, It is the policy of this facility to ensure that residents who require colostomy, urostomy, or ileostomy services receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Definitions: Ostomy - any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste. Colostomy - a stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall. The frequency of pouch changes and the products required for changing ostomy devices will be noted on the resident's person-centered care plan.		