

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  06/29/2025
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 0580  Level of Harm - Minimal harm or potential for actual harm  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.  (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to immediately consult with the resident's physician of 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 of 5 residents (Resident #34) reviewed for resident rights. -The facility failed in notifying Resident #34's physician on 06/24/25 right away when resident had a significant change in condition. Resident experienced a choking episode while eating his breakfast at 8:48AM on 06/24/25. This failure placed all residents in the facility who may experience a significant change in condition at risk for harm or injury if not reported to the physician in a timely manner. Record review of Resident #34's face sheet dated 06/26/25 revealed an [AGE] year-old man admitted to the facility on 02/24/22 and again on 04/03/23. Resident diagnoses included the following: Parkinson's Disease (disorder that effects movement, often included tremors {shaking}, aphasia (language disorder effecting a person's ability to communicate), cerebral infarction (a condition where blood flow to the brain is blocked causing brain tissue damage), and gastro-esophageal reflux disease (digestive disease in which stomach content irritates the food pipe lining). Record review of Resident #34's quarterly MDS dated [DATE] reflected a BIMS score of 14 indicating that resident cognition was intact. Section K (Swallowing/Nutrition Status) did not reflect coughing or choking during meals or when swallowing medications. Further review reflected mechanically altered diet. Section O (Special Treatments, Procedures, and Programs) did not reflect resident receiving-Speech-Language Pathology. Record review of Resident Physician Order Summary Report for the month of June 2025 reflected the following orders:-Dated 01/17/25 Speech to evaluate and treat as indicated-Dated 06/10/25 Xanax 0.5mg 1 tablet by mouth every 8 hours for anxiety-Dated 06/25/25 Stat order for chest X-ray Record review of Resident #34's MAR for the month of June 2025 reflected that the facility was administering medication Xanax 0.5mg 1 tablet my mouth every 8 hours. Record review of Resident #34's stat chest x-ray report dated 06/25/25 reflected no pleural effusion (buildup of fluid between the tissues that line the lungs and the chest).Record review of a swallow screen done by the Speech Language Pathologist done 06/28/25 for Resident #34. The Speech Language Pathologist recommended evaluation for possible downgrade in texture with RP sharing that resident had ongoing difficulties with swallowing and did not want to downgrade resident diet.Record review of Resident #34's Comprehensive Care Plan with last review date of 06/16/25 did not reflect resident being care planned for history of difficulty in swallowing or coughing when eating. Record review of Resident #34's Nursing Progress Notes reflected that the facility had not done an SBAR on 06/24/25 regarding resident choking episode but reflected the following documentation:-Dated 06/24/25 at 14:40 (2:40PM) facility spoke with the RP of Resident #34 regarding cough episode and the need to use oxygen. Per RP, resident getting to the end of the month and usually gets more anxious.-Dated 06/24/25 at 18:03 (6:03PM) Hospice was called to reorder lorazepam 1mg PRN, expected to be delivered 06/25/25. Observation on 06/24/25 at 8:48AM of Resident #34 sitting in wheelchair with bedside table in front of him. Resident breakfast tray was sitting on the bedside table Resident started choking excessively with face turning red and then blue. Resident call light was not in reach but sitting on resident bed by pillow that was at the head of resident bed. The surveyor called for help. Resident had eaten approximately 90 % of breakfast. On Resident plate was a 1/2 of toast and a small amount of what appeared to be oatmeal in bowl. LPN B arrived too room with 2 other staff members. When LPN B observed Resident #34's choking she said, Oh My GOD. LPN B attempted to apply the Heimlich maneuver while resident was sitting in wheelchair but was not successful. Resident continued to choke, and the surveyor called for more staff to come. LPN B was trying to lean Resident #34 forward in his wheelchair while patting on resident back. LPN B started preparing to place resident on oxygen via nasal cannula while LVN A agency nurse left the room and returned to room with oxygen saturation device to check resident oxygen saturation. At this time, resident was already receiving oxygen. By this time resident appeared to be in less stress with no further signs of cyanosis (blue skin). When LVN A agency nurse placed the oxygen saturation device on resident's finger, he said resident oxygenation was at 95%. Shortly after, LVN A agency nurse said resident oxygen saturation was ranging between 97-98 %. Resident remained on oxygen at the time of the readings. Before the surveyor exited Resident #34's room, she asked LPN B and LVN A agency nurse if they were going to notify the physician of resident choking incident. Both LPN B and LVN A agency nurse said yes repeatedly that they would notify</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and furnish services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 11 residents (CR #1 and Resident #34) reviewed for comprehensive care plans. The facility failed to care plan CR #1 for risk of elopement and document interventions prior to CR #1 eloping from the facility on 06/20/2025 around 4:45pm and did not know her whereabouts until 06/20/2025 around 8:40pm. The facility failed to assess and follow-up on Resident #34 in a timely manner when resident experienced excessive coughing/choking episode while eating breakfast on 06/24/25 at 8:48AM. This was determined to be an IJ on 6/26/25. The Administrator and DON were notified on 6/26/25 at 4:23pm. The DON and Administrator were provided with the IJ template on 6/26/25 at 4:27pm and a Plan of Removal was requested. The IJ was lowered on 06/29/2025 at 11:40am with the Administrator and DON. While the IJ was lowered, the facility remained out of compliance at a scope of isolation and a severity of no harm with potential for more than the minimal harm that is not an immediate jeopardy because of the facility's need for continued monitoring of implemented procedures. This failure could lead to residents not having their individual, medical, functional, and psychosocial needs identified and cause a physical or psychosocial decline in health. Findings Included: CR #1 Record review of CR #1's face sheet dated 06/25/2025 reflected an [AGE] year-old female originally admitted to the facility on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included Alzheimer's Disease (a neurodegenerative disorder which causes decline in memory, thinking and behavior), Type 2 diabetes mellitus (high blood sugar), chronic kidney disease, Major Depressive Disorder (a serious mental health condition characterized by persistent feelings of sadness, loss of interest in activities which disrupts the ability to function in everyday life), Hypertension (high blood pressure), overactive bladder, Dementia (a general term to describe decline in cognitive function, memory loss, difficulty communicating, impaired reasoning and changes in personality), and insomnia (difficulty or inability to sleep). Record review of CR #1's Quarterly MDS dated [DATE], CR #1 had a BIMS score of 6, indicating severe cognitive impairment. CR #1 required partial to moderate assistance with her ADLs including oral and personal hygiene, dressing, showering or bathing, and toileting. She required setup assistance for walking from 10 to 50 feet and supervision for walking 150 feet. CR #1 was frequently incontinent with urine and occasionally incontinent with bowel. Record review of CR #1's care plan, she was care-planned for elopement on 6/20/25, with interventions including 1 to 1 assistance, anticipating and meeting resident needs and explaining/reinforcing why behaviors were inappropriate and/or unacceptable to the resident. CR #1 was not previously care-planned for being at risk of elopement. Record review of CR #1's Kardex care sheet, undated, under toileting focus area CR #1 had interventions for staff to report any attempts to exit the facility to the IDT, family &amp; MD as indicated and record in the clinical record. She was also planned for IDT care plan over the phone with resident's RP to review current placement versus close/lock unit due to resident recent elopement. Record review of CR #1's progress notes, on 6/20/2025 at 1:34am she was resting in bed with no distress noted. On 6/20/2025 at 8:41pm, Interim DON was notified via phone that CR #1 was sitting on the floor by her walker near a college and taken to the ER. RP was notified 6/20/2025 at 9:01pm. On 06/21/2025 at 2:57am, a nurse documented that CR #1 was ordered to be on 1-to-1 supervision when she returned to the facility. CR #1 had returned from the hospital around 4:45am that day. A later note at 1:27pm, CR #1 was documented as being one-on-one care with aide due to an elopement on 6/20/2025 and CR #1 door was open, and resident was able to come in and out with supervision. Further review showed from September 2024 to June 2025, CR #1 was not mentioned having any exit-seeking or elopement incident. Record review of CR #1's elopement risk assessments completed 1/15/2025 and 3/19/2025, the assessments reflected CR #1 had a history of elopement or attempted to leave the facility without informing staff. No interventions were selected for either assessment. An additional elopement risk assessment was completed 06/12/2025 which reflected that CR #1 was marked yes for verbally expressing desire to go home, packing belongings or stayed near the exit, and there was a note reading usually resident sits at the lobby. CR #1 was also selected yes for having Alzheimer's, being cognitively impaired with poor decision-making skills related to intermittent confusion, cognitive deficits or</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>(continued on next page)</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review the facility failed to ensure that 1 (Resident #61) of 5 residents reviewed for hearing services, received proper treatment to maintain hearing capabilities. -The facility did not complete an Audiology (hearing) referral for Resident #61 who was hard of hearing until 06/27/25. -The facility failed to identify that Resident #61's hearing aids were not functioning properly when resident placed new batteries in hearing aids. This failure could place residents at risk for further decrease in communication, social engagement, and decrease in quality of life. Findings included: Record review of Resident #61's face sheet dated 06/26/25 revealed an [AGE] year-old male admitted to the facility on [DATE] and again on 04/02/24. Resident's diagnoses included dementia (brain disorder that causes problems with thinking, memory, and behavior), type 2 diabetes mellitus (body has trouble controlling blood sugar and using for energy), heart failure, heart disease, depression, adult failure to thrive, and hypertension (high blood pressure). Record review of Resident #61's quarterly MDS dated [DATE] section B (Hearing, Speech, and Vision) reflected resident had a hearing aide with moderate difficulty in hearing. Further review reflected a BIMS score of 4 indicating severe cognitive impairment. Record review of #61's Physician Order Summary Report for the month of June 2025 reflected the following order: -Dated 11/07/24 Audiology (hearing) as needed. Record Review of the facility Audiology binder for residents receiving services for Audiology did not reflect Resident #61 being on the list for services. Record review of Resident #61's Comprehensive Care Plan not dated reflected that Resident #61 was being care planned for impaired communication AEB hearing loss right/left both AEB wearing hearing aids. The interventions included: refer to audiology for hearing consult as ordered, report to the nurse changes in ability to communicate, possible factors which cause/make worse/better communication problems. Observation on 06/24/25 at 9:47AM was Resident #61 awake in bed with TV on in his room. While trying to communicate with resident, it was observed that resident was significantly having difficulty hearing the surveyor. Interview on 06/24/25 at 9:47AM with Resident #61 said he could not hear good and had been waiting on getting some help with his hearing aids. Interview on 06/26/25 at 12:43PM with MDS Consultant she said she had been working for the company for 8 years. The MDS Consultant said she was working in the place of the facility MDS nurse due to this staff member being on leave. The MDS Consultant said it was a team effort that consisted of herself, MDS nurse in the facility, charge nurse, nurse manager, and the DON that ensured residents were receiving the necessary social services. The MDS Consultant said she did not participate in the meetings held at the facility. The MDS Consultant said the surveyor would have to refer to the DON. The MDS Consultant said the facility did not have a full time Social Worker in the facility, but the Corporate Social Worker came to the facility when needed. Interview on 06/26/25 at 3:02PM with the DON said it was herself, and a Social Worker from a sister facility that was ensuring that residents that required social services including audiology were being seen by the physician. Interview on 06/26/25 at 4:46PM with LVN ZZ said he was an agency nurse and was Resident #61's primary care nurse . LVN ZZ said it was his first day working at the facility. LVN ZZ said he was not aware that Resident #61 was hard of hearing. LVN ZZ said he received report from the night nurse who he believed was an agency nurse as well that reported no changes. Interview on 06/27/25 at 2:11PM with the DON said she would have to see if a referral had been done for Resident #61 to receive audiology services. Interview on 06/27/25 at 3:15PM said she sent a referral to Audiology on 06/27/25 because Resident #61 was not on the list for audiology services. Interview on 06/28/25 at 10:29AM with the DON she said she assessed Resident #61 on 06/27/25 and that Resident #61 had hearing aids, but apparently something happened to his hearing aids. The DON said Resident #61 said his hearing aid was not working. The DON said Resident #61 had been seen by audiology services but could not locate a documentation of resident being seen by audiology. The DON said she did not speak with the staff to see if they were aware of Resident #61's hearing aids were not working. When the DON was asked what did it place Resident #61 at risk for when resident was hard of hearing, hearing aids not working properly, and resident not receiving audiology services, the DON said she did not know, and that the surveyor would have to speak with the Social Worker to answer that question. Interview on 06/28/25 at 12:27PM with the Social Worker via phone she said she only came to the facility once a month. The Social Worker said she was at the facility on June 6th and reviewed all residents' charts regarding their CODE status. The Social Worker said she spoke with the residents to see if they had any concerns about anything. The Social Worker said</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. There were 3 errors out of 37 opportunities, resulting in a 8 percent medication error involving for 1 of 14 residents (Resident #67) reviewed for medication errors. LVN J did not administer the full dose of carvedilol oral tablet 3.125 mg (carvedilol=medication used to help lower blood pressure and reduce the workload of the heart). Misoprostol oral tablet 100 mcg (misoprostol= medication used to protect the stomach against acid damage, and decreases the amount of acid produced by the stomach) and Famotidine oral tablet 40 mg (famotidine) (medication used to reduce the amount of acid produced in your stomach) as ordered by the Physician to Resident #67 on 6/24/25. These failures could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings included: Record review of Resident #67's face sheet, dated 6/24/25, revealed Resident #67 was admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnoses: chronic atrial fibrillation( irregular heart beat) atherosclerosis of coronary artery (fatty materials like build up inside your arteries) bypass graft(s), with angina pectoris, anorexia, diarrhea, unspecified, muscle wasting and atrophy, not elsewhere classified, other lack of coordination, muscle weakness (generalized other abnormalities of gait and mobility, cognitive communication deficit, dysphagia ( difficulty swallowing), depression ( mood swing), acute kidney failure, personal history of malignant neoplasm of breast (cancer) hemiplegia and hemiparesis ( paralysis of one side of the body) following cerebral infarction ( Stroke) affecting right dominant side, cerebral infarction, atrial fibrillation and flutter, gastro-esophageal reflux disease with esophagitis, without bleeding, acute cystitis ( sudden bladder infection) without hematuria (bleeding) , urinary tract infection, diabetes mellitus due to underlying condition with diabetic nephropathy and gastrostomy tube. Record review of Resident #67's quarterly MDS, dated [DATE], revealed Resident #67 had a BIMS score of 02 which indicated severe cognitive impairment. Resident #67 was dependent of staff for all ADLs. Record review of Resident#67's physician orders revealed the following: - Order date was 2/4/25 (carvedilol) give 1 tablet via g-tube every 12 hours related to chronic venous hypertension (idiopathic) with other complications. Famotidine oral tablet 40 mg (famotidine) give 1 tablet via peg-tube every 12 hours related to gastro-esophageal reflux disease with esophagitis. Misoprostol oral tablet 100 mcg give 1 tablet via g-tube before meals and at bedtime related to gastro-esophageal reflux disease with esophagitis, without bleeding. Sucralfate suspension 1gm/10ml take 10ml g tube before meal at bedtime. Observation on 6/24/25 at 8:45 AM, during medication pass with LVN J, Resident #67 was lying in bed. LVN J punched up blister packet of Carvedilol oral tablet 3.125 mg, Famotidine oral tablet 40 mg, Misoprostol oral tablet 100 mcg, and a bottle of Sucralfate suspension 1gm/10ml tablet from the medication and placed the medication on top of the medication cart. LVN J stated I have to check Resident #67's blood pressure before administering the medication and then picked up 60 cc syringe checked Resident residual via GT, it was 5cc return to stomach. At 9:13 AM LVN J went to prepare the medication left on the medication cart, stated I am sorry it took me a longer period to check the blood pressure. LVN J prepared the medication crushed each meds in a medication cup. At 9:21 am LVN J went in the Resident #67's room to administer medication after diluting it in water, LVN J did not stir or rinse the medications in the cup, LVN J had a lot of residue of Carvedilol, Famotidine and Misoprostol in the medication cup and after medication administration, LVN J was about to discard the medication cup. The nurse surveyor picked up the medication cups and showed LVN J the residual and she acknowledged the residuals in the medication cups and then added water to the medication cups and administered it via Resident #67's GT. Interview with LVN J on 6/24/25 at 5:45 PM, she said if medication was not given in totality the resident would not get required effects of the medication. LVN J said she had GT training, she was nervous. During an interview on 6/26/25 at 5:35 PM, the Administrator and DON they said the risk of not getting the medication as ordered by the doctor could affect therapeutic effectiveness. The DON said not giving medication as ordered by the doctor could cause more health issues and potency of the medication in the blood. She said she would be in-servicing the staff. Review of the facility policy revised 2012 and titled administering medications reflected, Medications shall be administered in a safe and timely manner, and as prescribed 3. Medications must be administered in accordance with the orders.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to properly store, label, and/or secure medications and biologicals for 1 of 4 medication carts (400 hall medication cart), in accordance with State and Federal laws, all drugs and were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to for 1 of 14 residents reviewed for medication administration (Resident #67). The facility failed to ensure Resident #67 medication was not left unattended on [DATE], 600-hall medication cart had medication open not dated. This failure could place residents at risk to having access to unauthorized medication and/or lead to possible harm or drug diversion and receiving the appropriate medications and not reaching the intended therapeutic dose and possible exacerbation of health conditions. Findings included: Record review of Resident #67's face sheet, dated [DATE], revealed Resident #67 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of: chronic atrial fibrillation (irregular heart beat) atherosclerosis of coronary artery (fatty materials like build up inside your arteries) bypass graft(s), with angina pectoris, anorexia, diarrhea, unspecified, muscle wasting and atrophy, not elsewhere classified, other lack of coordination, muscle weakness, generalized other abnormalities of gait and mobility, cognitive communication deficit, dysphagia (difficulty swallowing), depression (mood swing), acute kidney failure, personal history of malignant neoplasm of breast (cancer) hemiplegia and hemiparesis (paralysis of one side of the body) following cerebral infarction (Stroke) affecting right dominant side, cerebral infarction, atrial fibrillation and flutter, gastro-esophageal reflux disease with esophagitis, without bleeding, acute cystitis ( sudden bladder infection) without hematuria (bleeding) , urinary tract infection, diabetes mellitus due to underlying condition with diabetic nephropathy and gastrostomy tube. Record review of Resident #67's quarterly MDS, dated [DATE], revealed Resident #67 had a BIMS score of 02 which indicated severe cognitive impairment. Resident #67 was dependent of staff for all ADLs. Observation on [DATE] at 8:45 AM, during medication pass with LVN J, Resident #67 was lying in bed. LVN J pulled up a blister packet of Carvedilol oral tablet 3.125 mg, Famotidine oral tablet 40 mg, Misoprostol oral tablet 100 mcg, and a bottle of Sucralfate suspension 1gm/10ml tablet from the medication and placed the medication on top of the medication cart. LVN J stated I have to check Resident #67's blood pressure before administering the medication Resident#67's bp was 84/39 p87, LVN J recheck bp 88/51 p86, and she left the room to the parked medication cart to get the manual bp cuffs at 9:00 am and left the medication cart unlocked and then checked bp it was bp 163/62 p69, and then picked up 60 cc syringe checked Resident residual via GT, it was 5cc return to stomach, the door was wide open. At 9:13 AM LVN J went to prepared the medication left on the medication cart, stated am sorry it took me a longer period to check the bp. LVN J prepared the medication crushed the meds and in a medication cup. at 9:21 am LVN J went in the Resident #67's room to administer medication and left the door open, did not pulled the curtain in-between the roommate and she left her medication cart unlocked while administering the medication. Interview with LVN J on [DATE] at 5:45 PM, LVN J said she was nervous and forget to close the door. Observation on [DATE] at 12:43 PM with LVN GG, she said she checks the medication cart for expired whenever she works. 1. Voltaren (Arthritis pain) 150 gram (5.29 oz) open not dated and no name. Interview with LVN GG she did not know when it was opened, and it supposed to be dated. 2. Hydrocortisone cream 2 oz open not dated and no name. 3. Mupirocin cream USP 2% (30g net wet) opened not dated. 4. Clobetasol Propionate USP 0.05% opened not dated 45grams. 5. Triamcinolone Acetone 0.5% (15gm) opened not dated. In an interview with LVN GG on [DATE] at 1:04 PM she said she if the medications were opened and not dated, she would not know its effectiveness. In an interview on [DATE] at 3:00PM the DON and Consultant Pharmacist said the facility did not have any policy on dating the creams the pharmacist were not supposed to be dated it and the pharmacist dispensing those ointments always placed the opened date on them.</p>		

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  06/29/2025
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 (Residents #8 and #41) of 4 residents reviewed for infection control practices. -LVN A did not wipe his accu-check machine between after using it on Resident #8 and Resident #41 to check their blood glucose and did not store the accu-check machine properly to prevent infection on 06/24/2025. This failure could put residents at risk of a spread of infection and diseases due to not following infection control policies and procedures. Findings included: Record review of Resident #8's face sheet dated 06/25/2025, reflected she was a [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included obesity, type 2 diabetes mellitus (high blood sugar), personal history of urinary tract infections, hypertension (high blood pressure), blindness in one eye, and chronic kidney disease. Record review of Resident #41's face sheet dated 06/25/2025, reflected she was an [AGE] year-old female originally admitted on [DATE] and last re-admitted on [DATE]. Her medical diagnoses included type 2 diabetes mellitus (high blood sugar), hypotension (low blood pressure), iron deficiency, dementia (decline in cognitive function in areas like thinking, memory, and reasoning), and anxiety disorder (disorder characterized by prolonged periods of extreme worry). Observation on 6/24/25 at 9:47 AM of Resident #8's medication pass, revealed LVN A did not wipe the accu-check machine (machine used to measure blood sugar) after checking the blood glucose and placed it inside the medication cart. LVN A immediately went to Resident #41's room and checked Resident #41's blood glucose with the same machine. LVN A then placed it in his uniform pocket and then placed it in the top drawer of his medication cart without wiping or sanitizing the accu-check machine. In an interview on 6/24/25 at 10:23AM with LVN A, he said Residents #8 and #41 were not on isolation and in his previous state of employment, common practice was not to clean the accu-check machine between residents except if the residents were on contact isolation (a set of precautions to prevent spread of infectious diseases). LVN A said he did not have any orientation in the facility. LVN A said he knew wiping the accu-check machine was to prevent infection. He just started with the facility. In an interview on 6/26/2025 at 4:00pm with the DON, the DON said that she expected nurses to make sure they were preventing infections, agency staff were required to do competencies and quizzes before taking a shift, and that the DON would upload training to the agency staff communication portal so that transmission infection and disinfectant equipment could be addressed. The DON also said she expected staff to use the facility-provided antimicrobial wipes. Record review of the facility's policy on their infection prevention and control program last reviewed or revised 01/2025 read in part, all staff are responsible for following all policies and procedures related to the program, .environmental cleaning and disinfection shall be performed according to facility policy .all reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment.</p>		