STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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 of 4 residents (CR #1) when reviewed for quality of care. 1. The facility failed to notify CR#1's physician at 7 am when he had blurry vision, increased heart rate, shortness of breath, and his O2 levels dropped below baseline. 2. The first attempt at contact was made by text at 8:17 am but the NP did not respond until 9:30 am. CR#1 was transported to the hospital at 10am on 06/02/25, 3 hours after chief complaints of shortness of breath and unsuccessful interventions. An IJ was identified on 06/05/25. The IJ template was provided to the facility on [DATE] at 12:45pm. While the IJ was removed on 06/07/25, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ, due to the need for the facility to evaluate the effectiveness of the corrective action. This failure could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition and/or additional injury, paralysis or death. The findings included: Record review of CR#1's face sheet revealed a [AGE] year old man who was admitted to the skilled nursing facility on [DATE]. His admitting diagnoses were osteomyelitis (infection that has spread to the bone) of left foot and ankle, peripheral vascular disease, and atherosclerotic heart disease. Record review of CR#1's care plan disclosed that he was on antibiotic therapy related to a bacterial infection. No information was documented regarding the resident's anxiety or shortness of breath. Record review of CR#1's O2 stats documented that on 05/28/25, his O2 was 99%. On 05/29 his O2 stats read 98%. On 05/30/35, CR#1 O2 levels read 97%. On 05/31/25, his O2 levels read 96% and on 06/01/25, his O2 levels were at 95%. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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	Record review of CR#1's progress note dated 06/02/25 created by Nurse A documented that CNA A notified Nurse A that CR#1 complained of blurry vision and difficulty breathing. Nurse A elevated the head of bed and vitals read: BP 119/108, Heart rate 199, and O2 saturation 76%. O2 supplement maxed at 4 L were given and saturation increased to 86-87%. Norvsac 5mg, ASA (aspirin) 81 mg were administered, and resident was placed on the non-rebreather mask on 10 L. O2 saturation was increased to 90-92% and vitals read: BP 113/71, heart rate 98. CR#1 began to desaturate on the non-rebreather mask and was ordered to be sent out by NP at 9:20am. At 9:33am, 911 was called and EMS transferred CR#1 to the hospital at 10am. In an interview on 06/04/25 at 11:17 am, the NP recalled that she received a text message from Nurse A at 8:20 am on 06/02/25. She stated that if CR#1 was on a non-rebreather mask and he was still desaturating, there would be no reason for the Nurse to wait for a response from anyone (NP or PCP) because by that time CR#1 was in need of assistance. The NP checked her phone and saw that she responded to Nurse A at 9:20 am and ordered CR#1 to be sent out. The NP stated that when she arrived to the facility, CR#1 was already gone. In an interview on 06/04/25 at 12:10 pm, Nurse A stated she had worked at the facility for 1 year and worked the 6am-6pm shift. On Monday, 06/02/25, CNA A told her during breakfast that CR#1 had complaints of blurry vision and SOB (shortness of breath). When she went to check on him, CR#1 told her that he thought it could be his anxiety, and she explained that he had been experiencing increased anxiety over the last few days she worked. When she performed her assessment at 7am, CR#1 had rapid breathing and his pulse 199 bpm. When she noticed this, the first thing she did was elevate the bed for proper posture. Once she checked the vitals, she noticed his O2 was low, so she grabbed the portable O2 and gave him 2 L to help increase his O2. After CR#1 failed to return to baseline, Nurse A increased the O2 in the portable O2 machine to 4 L, which she stated was still not working. At 8 am, Nurse A placed a non-rebreather mask on CR#1 at 10 L, which helped increase his O2 to 90-91%. Although CR#1's O2 levels increased, he began to desaturate on the no-rebreather mask. Nurse A attempted to contact the NP at 8:17 am, 8:26 am, and sent a text at 8:20 am but she did not get a response. The DON was contacted, and she told Nurse A that she would have the NP assess CR#1 once she arrived at the facility sometime that day. At 9:20 am, the NP responded to Nurse A's text message and told her to send CR#1 out to the hospital because utilizing the non-rebreather mask would not be sustainable. Nurse A stated she contact 911 at 9:33 am and the resident was escorted to the hospital via EMS at 10 am. In an interview with the FM on 06/04/25 at 12:34 pm, she stated that CR#1 had complained more than once of having trouble breathing, but she felt the facility pushed it under the rug and said it was his anxiety. She stated that when she met CR#1 at the hospital, he could barely speak, and the ER doctor informed her that CR#1 might not pull through. The FM informed the investigator that CR#1 passed away at 3:30 am on 06/04/25. In an interview with CNA A on 06/04/25 at 2:14 pm, he stated that he went into CR#1's room to change him at 6:30 am and CR#1 informed him that he had blurry vision and was having trouble breathing. CNA A raised the head of the bed to assist with his breathing and went to inform Nurse A. He stated that during this time, CR#1 had his hands paced on his temples and he was crying, but he did not depict any pain or a headache. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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	In an interview with the DON on 06/04/25 at 2:45 pm, she stated that she could not say what time Nurse A informed her of CR#1's condition, but she was aware that he was having SOB. She explained that Nurse did place CR#1 on 2 L of O2, but CR#1 began to desaturate, and he was then placed on the non-rebreather mask so that he could obtain optimal levels of O2. The DON stated that when a resident had decreased O2 with SOB, the interventions would be to sit them up and let them lean over their bedside table to help open their lungs. While doing that, the nurse should check the pulse to see if the resident's O2 was increasing. The resident should be placed on O2 immediately if it was not working. Nurses were trained to call the NP or the PCP to know what the interventions were at the moment. If the NP or PCP don't answer, the DON stated she would try to call them and explained that she could not send a resident out to the hospital without a doctor's order because it was not in her scope of practice. If the DON could not reach the attending doctor, then she would contact the medical doctor , but she would only send them out if there was a doctor's order (unless they were code). In an interview on 06/04/25 at 3:51 pm with the HRN, she stated that CR#1 was admitted on [DATE] with SOB and his O2 was in the 70's. EMS tried to give CR#1 a BiPAP (machine that helped you breathe) but it was not tolerated well. She revealed that CR#1 had a fever of 101.4 Fahrenheit and review of his bloodwork showed that he had elevated Trinomen enzymes, which was an enzyme the heart releases when it is in distress. The HRN explained that when that enzyme was elevated, it signified that CR#1was under a ton of emotional and physical stress. Review of his radiology report showed that CR#1 had pneumonia and edema in both lungs. When informed that the nursing facility paced CR#1 on a non-rebreather mask, she explained that the mask gave a significant amount of oxygen and a person should not use the mask for a long amount of time. A non-rebreather mask should be used as a band-aid and 911 one should be called so that the resident could receive a higher level of care. The HRN stated that although a long time was subjective, if someone received a large amount of O2 for too long, it could reverse the body's oxygen regulating system. Record review of the facility's policy titled Change in a Resident's Condition or Status, revised 2016 stated that: 3. Our facility shall prom promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 4. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): a. accident or incident involving the resident; b. discovery of injuries of an unknown source; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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	c. adverse reaction to medication; d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; f. refusal of treatment or medications; g. need to transfer the resident to a hospital/treatment center; h. discharge without proper medical authority; and/or i. specific instruction to notify the Physician of changes in the resident's condition. The ADM and DON were notified on 06/05/25 at 12:45 pm that an IJ had been identified and an IJ template was provided. The following POR was approved on 06/06/25 at 10:38 am: Date: June 6, 2025 What corrective actions have been implemented for the identified residents? A. Resident CR#1 involved in alleged deficient practice was discharged to the hospital on 6/2/25. B. On 6/05/2025 at 01:35 pm the Administrator notified the Medical Director of alleged deficient practice. C. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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	Nurse Managers completed a 100% respiratory assessment of all residents residing in the facility for respiratory concerns on 6/05/2025, and none were identified. D. The DON and Nurse Managers audited the changes in conditions for the last 3 days for respiratory concerns and notification to the physician, no concerns were identified. Completion date 6/5/2025. E. On 6/05/2025 the DON was in-serviced on Notification of Changes in Residents Conditions by the Clinical Services Director. F. On 6/05/2025 LVN A was in-serviced on Notification of Changes in Residents Conditions by the DON. G. The Clinical Services Director reviewed facility policy on 6/05/2025 regarding notification of changes and no revisions were deemed necessary. How were other residents at risk to be affected by this deficient practice identified? A. All residents have the potential to be affected by the alleged deficient practice. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? A. An in-service was initiated on 6/05/2025 by the Corporate Clinical Service Director and Director of Nursing with the licensed nursing staff on notifying the attending physician immediately when a change occurs. Staff were instructed that if there is no response, they must call the Medical Director using the contact number posted at the nurse's station or initiate 911, based on the resident's clinical condition. Licensed nurses will not be allowed to return to work until they receive this in-service. Completion date 6/5/2025. a. Call 911 for life-threatening emergencies or rapidly deteriorating conditions, such as chest pain, severe respiratory distress, unresponsiveness, or suspected trauma. Always assess vital signs, consult facility protocols or providers as needed, and document the decision-making process thoroughly to ensure appropriate and timely care. B. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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	An in-service was initiated on 6/05/2025 by DON and the Administrator with the facility frontline on reporting any changes in resident conditions to the charge nurse. Completion date 6/5/2025. C. Newly hired nurses will be in-serviced by the Director of Nursing or designee on notifying the attending physician immediately when a change occurs and if there's no response instructed that if there is no response, they must call the Medical Director using the contact number posted at the nurse's station or initiate 911, based on the resident's clinical condition. Licensed nurses will not be allowed to return to work until they receive this in-service. Completion date 6/5/2025. Completion date 6/5/2025. How will the system be monitored to ensure compliance? A. The 24-hour report will be reviewed daily on the day shift capturing all shifts from the prior day by the DON/designee to audit nurse documentation in progress notes notifying the attending physician of patient change of conditions. On weekends, the Weekend Supervisor will conduct the review during the day shift for the previous 24-hour period. Discrepancies noted during reviews will be immediately corrected by contacting the attending physician of the change of condition and completing documentation in the patient's progress note. Further training will be provided as identified by the nurse manager who identified the discrepancy when and if necessary. Review will be documented on an audit report form. B. The DON/designee will review 24-hour report to ensure nurses document timely notification to the attending physician of resident changes of condition 2x week X 6 weeks. Review will be documented on an audit report form. C. Administrator will review the audit reports on a weekly basis to ensure nurse managers are following the plan of correction for six weeks. Review will be documented on an audit report form. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 6/05/2025 with the Medical Director. The Medical Director has reviewed and agrees with this plan. The Surveyor monitored the POR from 06/06/25 - 06/07/25 as followed: Review of an in-service titled Notification in change in condition dated 06/05/25, 06/06/25, 06/07/25 documented that all nursing staff had been in-serviced. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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	Review of the in-service date 06/05/25 revealed that the DON and the nurse managers on notifying the attending physician immediately when there is a change in condition in a resident's condition. During interviews on 06/05/25 from 1:38 pm - 4:00 pm and on 06/07/25 from 8:47 pm - 9:10 pm, nurses from the 6am-6pm and 6pm-6am shift were asked to review what was covered during their in-services. This included 8 LVN's and 2 RN's. All staff stated that in the event that a resident was experiencing a change in condition, the protocol would be to first assess the resident and If there was a deviation from their baseline, their NP or MD should be notified immediately. If the resident has interventions in place, nurses are to follow them or follow the orders given by the NP/MD. If the interventions were not sustainable, 911 should be called so that the resident can receive a higher level of care. It was verbalized that the chain in notification would be that the NP would be notified first and if there was no answer, an attempt would be made to the MD, and the immediate scalation would be to call 911. If contact is made with the NP and an Intervention had been started, all nurses should contact the family and facility administration. During interviews on 06/05/25 from 1:38 pm - 4:00 pm and on 06/07/25 from 8:47 pm - 9:10 pm, nurses from the 6am-6pm and 6pm-6am shift were asked to review what was covered during their in-service. This was reviewed by 11 CNA's who worked the 6am-2pm, 2pm- 10pm, and 10pm- 6am shifts. All aids had knowledge on what a change in condition looked like which could range from a skin tear or vomiting, to dizziness or shortness in breath. Aids were aware that if there was a change in condition in a resident, a nurse should be notified immediately. They stated that if the floor nurse was not available, they would inform another nurse and if that nurse was not available, they would immediately notify the ADON or DON. Review of the resident assessments to identify changes in respiratory systems and vision conditions revealed no residents were affected. Review of the resident 24-hour charts from dates 06/05/25-06/09/25 revealed that all staff were following the protocol in regards to physician notification in changed in condition and appropriate documentation in PCC. This reported has been monitored daily and was reviewed up into the exit date. Review of the Facility's QAPI Agenda, dated 06/05/25, reflected that the MD had reviewed and agreed with the plan. An amendment was made to the IJ template on 06/09/25 to include CR#2. The ADM and DON were notified on 06/07/25 9:40 pm that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - 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 interview and record review, the facility failed to ensure based on the comprehensive assessment of a resident, that resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 2 of 4 residents (CR #1, CR#2) reviewed for quality of care. 1. The facility failed to notify CR#1's physician at 7 am when he had blurry vision, increased heart rate, shortness of breath, and his O2 levels dropped below baseline. 2. The first attempt at contact was made by text at 8:17 am but the NP did not respond until 9:30 am. CR#1 was transported to the hospital at 10am on 06/02/25, 3 hours after chief complaints of shortness of breath and unsuccessful interventions. 3. The facility failed to notify the Doctor when CR#2 began to have open wounds to her lower legs, identified on 09/24/24. As wounds progressed, no treatments, new orders, or interventions were initiated. Resident was admitted to the hospital on [DATE] with a diagnosis of cellulitis to the left and right lower limbs. An IJ was identified on 06/05/25 at 12:45 pm. The IJ template was provided to the facility on [DATE] at 12:45pm. While the IJ was removed on 06/07/25 , the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not IJ, due to the need for the facility to evaluate the effectiveness of the corrective action. These failures could place residents at risk for a delay in treatment or diagnosis, a decline in the resident's condition and/or additional injury, paralysis or death. The findings included: CR#1 Record review of CR#1's face sheet revealed a [AGE] year old man who was admitted to the skilled nursing facility on [DATE]. His admitting diagnoses were osteomyelitis (infection that has spread to the bone) of left foot and ankle, peripheral vascular disease, and atherosclerotic heart disease. Record review of CR#'s care plan disclosed that he was on antibiotic therapy related to a bacterial infection. No information was documented regarding the resident's anxiety or shortness of breath. Record review of CR#1's O2 stats documented that on 05/28/25, his O2 was 99%. On 05/29 his O2 stats read 98%. On 05/30/35, CR#1 O2 levels read 97%. On 05/31/25, his O2 levels read 96% and on 06/01/25, his O2 levels were at 95%. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's progress note dated 06/02/25 created by Nurse A documented that CNA A notified Nurse A that CR#1 complained of blurry vision and difficulty breathing. Nurse A elevated the head of bed and vitals read: BP 119/108, Heart rate 199, and O2 saturation 76%. O2 supplement maxed at 4 L were given and saturation increased to 86-87%. Norvsac 5mg, ASA (asprin) 81 mg were administered, and resident was placed on the non-rebreather mask on 10 L. O2 saturation was increased to 90-92% and vitals read: BP 113/71, heart rate 98. CR#1 began to desaturate on the non-rebreather mask and was ordered to be sent out by NP at 9:20am. At 9:33am, 911 was called and EMS transferred CR#1 to the hospital at 10am. In an interview on 06/04/25 at 11:17 am, the NP recalled that she received a text message from Nurse A at 8:20 am on 06/02/25. She stated that if CR#1 was on a non-rebreather mask and he was still desaturating, there would be no reason for the Nurse to wait for a response from anyone (NP or PCP) because by that time CR#1 was in need of assistance. The NP checked her phone and saw that she responded to Nurse A at 9:20 am and ordered CR#1 to be sent out. The NP stated that when she arrived to the facility, CR#1 was already gone. In an interview on 06/04/25 at 12:10 pm, Nurse A stated she had worked at the facility for 1 year and worked the 6am-6pm shift. On Monday, 06/02/25, CNA A told her during breakfast that CR#1 had complaints of blurry vision and SOB (shortness of breath). When she went to check on him, CR#1 told her that he thought it could be his anxiety, and she explained that he had been experiencing increased anxiety over the last few days she worked. When she performed her assessment at 7am, CR#1 had rapid breathing and his pulse 199 bpm. When she noticed this, the first thing she did was elevate the bed for proper posture. Once she checked the vitals, she noticed his O2 was low, so she grabbed the portable O2 and gave him 2 L to help increase his O2. After CR#1 failed to return to baseline, Nurse A increased the O2 in the portable O2 machine to 4 L, which she stated was still not working. At 8 am, Nurse A placed a non-rebreather mask on CR#1 at 10 L, which helped increase his O2 to 90-91%. Although CR#1's O2 levels increased, he began to desaturate on the no-rebreather mask. Nurse A attempted to contact the NP at 8:17 am, 8:26 am, and sent a text at 8:20 am but she did not get a response. The DON was contacted, and she told Nurse A that she would have the NP assess CR#1 once she arrived at the facility sometime that day. At 9:20 am, the NP responded to Nurse A's text message and told her to send CR#1 out to the hospital because utilizing the non-rebreather mask would not be sustainable. Nurse A stated she contact 911 at 9:33 am and the resident was escorted to the hospital via EMS at 10 am. In an interview with the FM on 06/04/25 at 12:34 pm, she stated that CR#1 had complained more than once of having trouble breathing, but she felt the facility pushed it under the rug and said it was his anxiety. She stated that when she met CR#1 at the hospital, he could barely speak, and the ER doctor informed her that CR#1 might not pull through. The FM informed the investigator that CR#1 passed away at 3:30 am on 06/04/25. In an interview with CNA A on 06/04/25 at 2:14 pm, he stated that he went into CR#1's room to change him at 6:30 am and CR#1 informed him that he had blurry vision and was having trouble breathing. CNA A raised the head of the bed to assist with his breathing and went to inform Nurse A. He stated that during this time, CR#1 had his hands paced on his temples and he was crying, but he did not depict any pain or a headache. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview with the DON on 06/04/25 at 2:45 pm, she stated that she could not say what time Nurse A informed her of CR#1's condition, but she was aware that he was having SOB. She explained that Nurse did place CR#1 on 2 L of O2, but CR#1 began to desaturate, and he was then placed on the non-rebreather mask so that he could obtain optimal levels of O2. The DON stated that when a resident had decreased O2 with SOB, the interventions would be to sit them up and let them lean over their bedside table to help open their lungs. While doing that, the nurse should check the pulse to see if the resident's O2 was increasing. The resident should be placed on O2 immediately if it was not working. Nurses were trained to call the NP or the PCP to know what the interventions were at the moment. If the NP or PCP don't answer, the DON stated she would try to call them and explained that she could not send a resident out to the hospital without a doctor's order because it was not in her scope of practice. If the DON could not reach the attending doctor, then she would contact the medical doctor , but she would only send them out if there was a doctor's order (unless they were code). In an interview on 06/04/25 at 3:51 pm with the HRN, she stated that CR#1 was admitted on [DATE] with SOB and his O2 was in the 70's. EMS tried to give CR#1 a BiPAP (machine that helped you breathe) but it was not tolerated well. She revealed that CR#1 had a fever of 101.4 Fahrenheit and review of his bloodwork showed that he had elevated Trinomen enzymes, which was an enzyme the heart releases when it is in distress. The HRN explained that when that enzyme was elevated, it signified that CR#1was under a ton of emotional and physical stress. Review of his radiology report showed that CR#1 had pneumonia and edema in both lungs. When informed that the nursing facility paced CR#1 on a non-rebreather mask, she explained that the mask gave a significant amount of oxygen and a person should not use the mask for a long amount of time. A non-rebreather mask should be used as a band-aid and 911 one should be called so that the resident could receive a higher level of care. The HRN stated that although a long time was subjective, if someone received a large amount of O2 for too long, it could reverse the body's oxygen regulating system. CR#2 Record review of CR#2's face sheet revealed a ninety-one-year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were end stage heart failure, atherosclerotic heart disease, Stage 3 chronic kidney disease, dementia (memory impairment), and hypertension (high blood pressure). Record review of CR#2's care plan revealed that she had a communication problem related to dementia and had a pacemaker related to atrial fibrillation. In an interview on 06/09/25 at 1:17 pm, the FM2 stated that she had went on vacation from 09/16/24-09/23/24. When she returned to visit the facility on 09/24/24, she noticed swelling on CR#2's hand and she noticed there were small open red wounds on her right and left leg. The nursing staff were informed (who was not specified) of the swelling and wounds and she assumed treatment would begin. On 09/25/25, the FM2 returned to the facility and noticed the red wounds on her legs were getting worst and the swelling to the hand had remained the same. This was documented by camera phone at on 09/25/24 at 4:06 pm The FM2 immediately flagged down the nurse and told them that she wanted the doctor to come and check on CR#2. The FM2 also requested to give CR#2 a cold compress for her hands. She took another picture on 09/27/24 at 11:53 am that showed the wounds had begun to move up her legs. The FM2 stated that when the doctor finally arrived, she stated he took one look at CR#2 and sent her to the hospital on [DATE]. The FM2 disclosed that CR#2 passed away on 10/04/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the photographs submitted by FM2 regarding the wounds on her legs showed that on 09/25/24, there were two wounds that consisted of a deep cranberry color. Seven smaller markings could also be seen that were very faint in color and did not appear to go below the surface of the skin. On 09/27/24, the picture showed that the wounds had spread up her lower extremities. There were over 10 small deep red wounds that ranged from a deep cranberry color to bright red. Record review of CR#2's Weekly Skin review dated 09/24/24 at 7:57 pm revealed open, red, scabbed over areas were identified on her (BLE) bilateral lower extremities. Note stated that CR#2 was unable to identify how scabbed areas to BLE occurred. Notification of physician and the date the physician was notified was left blank on the assessment. Record review of CR#2's orders revealed no orders initiated for treating the open areas on her legs. Record review of CR#2's TAR (treatment administration record) for September 2024 reflected that new treatments had been started to tend to BLE. Record review of CR#2's progress note documented by Nurse B on 09/24/24 at 1:39 pm wrote that This nurse placed a call to neighborhood x-ray to find out when a Tech will be here for her left arm doppler and she said a Tech will come soon. Record review of CR#2's progress note documented by Nurse A on 09/24/24 at 10:15 pm revealed that a CIC (change in condition) note was added. This note identified CR#2 had an episode of confusion where she wondered into hallway screaming and became more upset when she was redirected. A Urinalysis culture was ordered by the doctor. Record review of CR#2's progress note documented by Nurse A on 09/25/24 at 5:43 pm wrote Neighborhood x-ray notify checking on the Left ARM Venous Doppler ETA, spoke to x-ray tech she states she will have tech notify facility on the ETA as soon as possible. Record review of CR#2's progress note documented by Nurse C on 09/25/24 at 4:34 pm wrote Urine sample collected this morning and put in collection refrigerator located in soiled utility room. Lab informed of specimen and is scheduled to pick up in am 9/26. Record review of CR#2's progress note documented by Nurse B on 09/27/24 at 7:55 am wrote Resident pickup by EMS and is being transported to , she denies discomfort or aches this morning after taking her morning meds and had her breakfast, copies of her face sheet, med list and doppler result is sent with her, she is taking her phone, charger and kindle with her, report called in and I spoke with nurse, daughter notified. Record review of CR#2's hospital admission record from the facility, dated 09/27/24, the documented the problem of right leg cellulitis (bacterial skin infection that causes redness, swelling, pain, and warmth in the affected are), right leg superficial wounds, congestive heart failure, and acute chronic respiratory failure with hypoxia (failure of oxygen to reach the body's tissue). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 06/05/25 at 1:44 pm, Nurse B stated that when CR#2 was last at the facility, she remembered that CR#2 had experienced swelling in her hand and Nurse B reached out to the doctor to receive an order for a doppler to check for circulation. She could not remember much regarding this resident and she could not recall if there open areas on her legs. An attempt for an interview was made on 06/09/25 at 3:48 pm with the previous WCN. A voicemail was left and a text message was sent requesting a call back. In an interview on 06/09/25 at 4:41 pm with Dr. D, he stated that he remembered CR#2 to have advanced dementia and congestive heart failure. He could recall leg swelling but no recollection of an infection. He stated that because she was one of his long-term care patients, he would visit the resident once every 3 months but if the staff called him when something bad happened, he would come out and visit the resident. He stated he did no t receive a call from the nurses regarding anything bad that would prompt him to come out aside from the call he got from the FM2. Record review of the facility's policy titled Change in a Resident's Condition or Status, revised 2016 stated that: 1. Our facility shall prom promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). 2. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medication; d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. refusal of treatment or medications; g. need to transfer the resident to a hospital/treatment center; h. discharge without proper medical authority; and/or i. specific instruction to notify the Physician of changes in the resident's condition. The ADM and DON were notified on 06/05/25 at 12:45 pm that an IJ had been identified and an IJ template was provided. The following POR was approved on 06/06/25 at 12:45 pm: Date: June 6, 2025 NF XXX submits the following Plan of Removal for the alleged failure to ensure treatment and care was provided to CR #1 consistent with professional standards of practice on 06/05/25. The Texas Department of Health and Human Services entered the facility on June 4, 2025, for a Complaint Survey. During the survey process an IJ (Immediate Jeopardy) was cited regarding F684 - Quality of Care, consistent with the resident rights that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. The facility failed to ensure CR # 1 receives treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices in that: the facility failed to contact 911 after CR #1's O2 dropped and did not return to baseline after the use of supplemental oxygen interventions. The resident was transported to hospital at 10am on 6/2/25, 3 hours after chief complaints of shortness of breath and unsuccessful interventions. Immediate action: What corrective actions have been implemented for the identified residents? CR #1 discharged from the facility on 6-2-25 to the hospital and did not return to the facility. o On 6/05/2025 at 01:35 pm the Administrator notified the Medical Director of alleged deficient practice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o On 6-5-25, the Clinical Service Director in-serviced the nurse managers to include the DON to notify the attending physician immediately when there is a change in the resident's condition. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care. The DON/designees will be notified by licensed nurses when there is a change in residents' condition and interventions attempted to include residents' response to the interventions. The DON/designees will determine if improvement is sustained or if 911 needs to be called and resident transported to the hospital to receive a higher level of care. Completion date 6/5/2025. o On 6-5-25, DON/designees in-serviced all licensed nurses (full-time, part-time, and PRN) to notify the attending physician immediately when there is a change in the resident's condition. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care. The DON/designees will be notified by licensed nurses when there is a change in residents' condition and interventions attempted to include residents' response to the interventions. The DON/designees will determine if improvement is sustained or if 911 needs to be called and resident transported to the hospital to receive a higher level of care. Completion date 6/5/2025. o On 6-5-25, DON/Nurse Managers assessed all residents for changes in respiratory system and vision condition. No residents were found to be affected. o On 6-5-25, DON/designees audited residents' charts for changes in respiratory system and vision condition in the past 72 hours. No residents were found to be affected. o The training is immediately notifying the attending physician when there is a change in the residents' condition. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care will be ongoing. Training to be conducted during the orientation of newly hired licensed nursing staff (full-time, part-time, and PRN). The DON/designees to provide oversight and ensure compliance. Completion date 6/5/2025. o No licensed nursing staff will be allowed to work without receiving the in-service on the regarding timely notifying the attending physician timely when there is a change in the residents' condition. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 6-5-25, the facility Administrator notified the Medical Director via phone. Items discussed were: IJ (Immediate Jeopardy) was cited on 6-5-25 as evidenced by facility's failure to: F684 - Quality of Care o On 6-5-25, the Clinical Service Director in-serviced the nurse managers to include the DON to notify the attending physician immediately when there is a change in the resident's condition. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care. Completion date 6/5/2025. o On 6-5-25, DON/designees in-serviced all licensed nurses (full-time, part-time, and PRN) to notify the attending physician timely when there is a change in the resident's condition. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care. o On 6-5-25, DON/Nurse Managers assessed all residents for changes in respiratory system and vision condition. No residents were found to be affected. o On 6-5-25, DON/designees audited residents' charts for changes in respiratory system and vision condition in the past 72 hours. No residents were found to be affected. o The training regarding timely notifying the attending physician timely when there is a change in the residents' condition. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care will be ongoing. Training to be conducted during the orientation of newly hired licensed nursing staff (full-time, part-time, and PRN). The DON/designees to provide oversight and ensure compliance. o No licensed nursing staff will be allowed to work without receiving the in-service on the regarding timely notifying the attending physician timely when there is a change in the residents' condition. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care. How were other residents at risk to be affected by this deficient practice identified? (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A. All residents have the potential to be affected by the alleged deficient practice. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? A. An in-service was initiated on 6-5-25 by the Corporate Clinical Service Director and Director of Nursing with the licensed nursing staff on notifying the attending physician timely when a change of condition occurs. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care. Licensed nurses will not be allowed to return to work until they receive this in-service. Completion date: 6-5-25. B. An in-service was initiated on 6-5-25 by DON and designees with the facility licensed nursing staff on reporting any changes in resident conditions notifying the attending physician timely when a change of condition occurs. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care. Completion date: 6-5-25. C. Newly hired nurses will be in-serviced by the Director of Nursing or designee on timely notifying the attending physician of patient change of conditions timely when a change of condition occurs. If there is no sustained improvement during interventions at the facility, then 911 is to be contacted to transport resident to the hospital to receive a higher level of care. How will the system be monitored to ensure compliance? A. The 24-hour report will be reviewed daily during the day shift by the Director of Nursing (DON) or designee to audit nurse documentation in progress notes, specifically ensuring timely notification to the attending physician regarding any resident change in condition. On weekends and holidays, the Weekend Supervisor will conduct this review during the day shift for the prior 24-hour period. If there is no sustained improvement during in-house interventions, 911 will be contacted to transport the resident to the hospital for a higher level of care. Any discrepancies identified during these reviews will be immediately corrected by notifying the attending physician and completing appropriate documentation in the resident's progress notes. Additional staff training will be provided as needed, based on findings by the Nurse Manager. All reviews will be documented on an audit report form twice weekly for six weeks. B. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The administrator will review the audit reports on a weekly basis to ensure nurse managers are following the plan of correction for six weeks. The review will be documented on an audit report form. C. This will be reviewed monthly in QAPI until sustained compliance is achieved. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 6-5-25 with the Medical Director. The Medical Director has reviewed and agrees with this plan. The Surveyor monitored the POR from 06/06/25 - 06/07/25 as followed: Review of an in-service titled Notification in change in condition dated 06/05/25, 06/06/25, 06/07/25 documented that all nursing staff had been in-serviced. Review of the in-service date 06/05/25 revealed that the DON and the nurse managers were trained on notifying the attending physician immediately when there is a change in condition in a resident's condition. During interviews on 06/05/25 from 1:38 pm - 4:00 pm and on 06/07/25 from 8:47 pm - 9:10 pm, nurses from the 6am-6pm and 6pm-6am shift were asked to review what was covered during their in-services. This included 8 LVN's and 2 RN's. All staff stated that in the event that a resident was experiencing a change in condition, the protocol would be to first assess the resident and if there was a deviation from their baseline, their NP or MD should be notified immediately. If the resident has interventions in place, nurses were to follow them or follow the orders given by the NP/MD. If the interventions were not sustainable, 911 should be called so that the resident can receive a higher level of care. It was verbalized that the chain in notification would be that the NP would be notified first and if there was no answer, an attempt would be made to the MD, and the immediate scalation would be to call 911. If contact is made with the NP and an Intervention had been started, all nurses should contact the family and facility administration. During interviews on 06/05/25 from 1:38 pm - 4:00 pm and on 06/07/25 from 8:47 pm - 9:10 pm, nurses from the 6am-6pm and 6pm-6am shift were asked to review what was covered during their in-service. This was reviewed by 11 CNA's who worked the 6am-2pm, 2pm- 10pm, and 10pm- 6am shifts. All aides had knowledge on what a change in condition looked like which could range from a skin tear or vomiting to dizziness or shortness in breath. Aides were aware that if there was a change in condition in a resident, a nurse should be notified immediately. They stated that if the floor nurse was not available, they would inform another nurse and if that nurse was not available, they would immediately notify the ADON or DON. Review of the resident assessments to identify changes in respiratory systems and vision conditions revealed no residents were affected. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident 24-hour charts from dates 06/05/25-06/09/25 revealed that all staff were following the protocol in regard to physician notification in changed in condition and appropriate documentation in PCC. This reported has been monitored daily and was reviewed up into the exit date. Review of the Facility's QAPI Agenda, dated 06/05/25, reflected that the MD had reviewed and agreed with the plan. An amendment was made to the IJ template on 06/09/25 to include CR#2. The ADM and DON were notified on 06/07/25 9:40 pm that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of isolated that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 40 of 106 residents reviewed for kitchen safety. 1. Dietary staff failed to ensure all perishable items were fresh before serving to residents. 2. During the lunch service on 06/09/25, Resident #1 took a sip of chocolate milk that had an expiration date of 05/19/25. This failure could place residents at risk of contracting a food borne illness. Findings include: Record review of Resident #1's face-sheet revealed a [AGE] year-old woman who was admitted to the facility on [DATE]. Her admitting diagnoses were type 2 diabetes, major depressive disorder, and morbid obesity. Record review of Resident #1's MDS (Minimum Data Set) assessment, Section C Cognitive Patterns dated 06/03/25 revealed a score of 11, signifying moderately impaired cognition. Record review of Resident #1's care plan revealed that she was dependent on staff for activities, cognitive stimulation, and social interaction. Resident #1 had the potential for fluid deficit related to poor intake and she was encouraged to drink the fluids of her choice. It was also documented that she experienced symptoms of GERD (gastro-intestinal reflux disorder). In an observation and interview on 06/09/25 at 11:43 am, Resident #1 was laying in bed and was in a pleasant disposition. She explained that she was doing amazing and that she had been at the facility for several years. As she began to describe her experience with the investigator, an aide (name not taken) brought the resident's lunch. On the tray with Resident#1's lunch was an 8 fl oz carton of chocolate milk. The aide set up the tray for Resident #1 and she continued her conversation with the investigator. When Resident #1 opened the carton of chocolate milk and took a sip, she yelled Oh God!! What is the date on this?. The expiration date on the milk was 05/19/25. Resident #1 stated that is terrible! They don't even check the date. The investigator immediately flagged down the ADON in the hallway and let her know that they needed to check and remove all the milk that had been passed during lunch. Alongside the ADON and aides, they removed the milk from each resident's lunch tray. On the halls, most of the milk was poured into plastic cups and was covered with plastic wrap. The cups that were not wrapped with plastic denied being consumed by the residents. On one of the halls, the investigator grabbed a cup and smelled the milk. The smell was sour and pungent. In the kitchen, were 4 empty cartons of chocolate milk set on the counter. The Dietary Aide walked the investigator to the walk-in kitchen and the date was checked on all the food. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676165	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Tomball	250 School Street Tomball, TX 77375

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/09/25 at 12:08 pm with DA A, she stated that DA B and herself were responsible for passing out the milk during the lunch service. DA A said they opened 6 cartons of chocolate milk and poured them into plastic cups. Resident #1 was the only person who got a full carton during her meal. DA A disclosed that she did not check the date on the milk nor did she smell the milk for freshness. She stated that it was the responsibility of the dietary aides to ensure that all food and beverages were fresh for the residents. In an interview on 06/09/25 at 12:10 pm with the DM , she stated that DA A didn't check the date on the milk. She explained that she saw the cartons of expired chocolate milk mixed in a crate with other cartons of milk and she separated them out. She stated that she would check the date on perishable items daily, but she guessed that the night shift forgot to pour out the expired cartons. The expiration date of 05/19/25 was reiterated to the DM. She said that she understood, and the date was the reason why she had them separated. The DM stated the process for prepackaged items was to check them before food service. The DM explained that the harm in a resident consuming expired milk was that they could get sick. In an interview on 06/09/25 at 3:01 pm with the ADM, he stated that he was made aware of the expired milk during the lunch service and he in-serviced the dietary staff and the nursing staff. The in-service covered communication, checking the dates on all items, and nursing staff checking the dates on tray items. The ADM affirmed that the expectation of fresh food fell on everybody. Record review of the facility's policy titled Facility Nutrition Program, revised April 2007 documented that A Food Services Manager (who may be a Working Supervisor) will oversee the activities and functions of the kitchen staff (i.e., those responsible for storing, preparing, and delivering meals), including food storage and preparation, sanitation issues, personnel matters, and menu planning and preparation.