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	11/24/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 1 facility and 2 of 10 staff (MA A and LVN A) reviewed for misappropriation. - The facility failed to report to the State Survey Agency allegations of drug theft and misappropriation of resident property by MA A. - The facility failed to report to the State Survey Agency drug theft of 80 controlled substance tablets that occurred when LVN A left the medications unattended at the nursing station on [DATE]. This failure could result in the state agency being unaware of alleged misappropriation of resident property and drug diversion. Findings Include: MA A Record review of the HHSC TULIP (system to which providers report accidents and incidents) on [DATE] revealed, multiple anonymous complaints were submitted that alleged MA A misappropriated multiple resident medications and items. The facility did not submit any Facility Reported Incidents regarding alleged misappropriation by MA A. Record review of an undated chat conversation in a social media app at 09:39 AM revealed, MA As status was active 1 h ago. MA A sent a 14 second video of her injecting Mounjaro (an injectable weight loss medication) into her lower left abdomen. In response the unknown individual responding What are you doing pook to which MA A responded Mounjaro. I wanna get my own script but until I can afford the facility gone supply this shit , to which the unknown induvial responded Oh ok. Record review of the Administrator's Internal Investigation Report signed by the Administrator and ADON on [DATE] revealed, employee name: MA A; Date of Incident Report: [DATE]; Investigator: Administrator; Additional Participants: ADON. Summary of Allegations: On [DATE], the facility received multiple anonymous phone calls alleging that [MA A] was stealing medications. The caller specifically asked if the facility employed her and claimed she had been taking medications from the carts. These calls were very short and the caller refused to leave a name or how she knew of this information. Immediate Actions Taken: Medication Audit- [ADON] immediately conducted a thorough audit of all medication cart; Result: No missing or unaccounted medications were found. Law Enforcement Involvement: On [DATE], officers from the [police department] entered the facility requested to speak with the Administrator regarding similar anonymous reports. The Administrator confirmed to officers that internal audit had been completed with no discrepancies. The police interviewed [MA A] on-site. Following the interview, law enforcement expressed no ongoing concerns and took no further action. Findings: No missing medications were identified. There is no evidence supporting the allegation of theft or diversion. The allegations appear to be malicious in nature, potentially made by an individual known to [MA A] from a previous place of employment. Conclusion: Based on the internal audit, staff interviews, and law enforcement input, there is no substantiated evidence of medication diversion or misconduct by [MA A]. No further investigation is warranted at this time. Corrective/Preventative Measures: continued routine medication carts audits will be performed. Staff reminded to immediately report any concerns of potential diversion. Documentation of this investigation will be retained in the Administrator's reference. Record review of the Police Department Call Record Dated [DATE] revealed, on [DATE] at 03:26 PM the police department received an anonymous call regarding past theft at the facility. The complainant reported that they had observed MA A misappropriate medications at the facility. On [DATE] at 03:57 PM officers spoke to the Administrator at the facility and he notified them that the facility had received multiple calls that accused MA A of drug diversion but the Administrator did not believe the allegation because all the med counts had been accurate since MA A started working at the facility. Observation of an undated video and untimed video revealed, MA A injecting Mounjaro into her lower left abdomen in the facility central supply closet. A cabinet with a sign attached that read PLEASE DO NOT PUT OTC MEDS IN THIS CABINET FROM MED AIDE OR NURSES CARTS. PLACE ON CENTRAL SUPPLY. The rest of the texts could not be interpreted because the sheet was torn and folded. In interview on [DATE] at 09:35 AM, the Administrator said in December of 2024 the facility received multiple anonymous complaints that MA A was misappropriating resident

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect and injury of unknown origin, are thoroughly investigated and results reported of all investigations to the State Survey Agency, within 5 working days of the incident for 1 of 1 facility reviewed for misappropriation. - The facility Administrator failed to thoroughly investigate, put corrective actions in place and to report the results of the investigation to the state agency within 5 working days of the incident following allegations of drug theft and misappropriation of resident property by MA A - The facility Administrator failed to thoroughly investigate, put appropriate corrective actions in place and to report the results of the investigation to the state agency within 5 working days of the incident following drug theft of 80 controlled substance tablets that occurred on [DATE]. These failures could place residents at risk of drug diversion and misappropriation. Findings Include: MA A Record review of the facility's employee records revealed, MA A's date of hire was [DATE] and she was hired as a medication aide. Record review of the Administrator's Internal Investigation Report signed by the Administrator and ADON on [DATE] revealed, employee name: MA A; Date of Incident Report: [DATE]; Investigator: Administrator; Additional Participants: ADON. Summary of Allegations: On [DATE], the facility received multiple anonymous phone calls alleging that [MA A] was stealing medications. The caller specifically asked if the facility employed her and claimed she had been taking medications from the carts. These calls were very short and the caller refused to leave a name or how she knew of this information. Immediate Actions Taken: Medication Audit- [ADON] immediately conducted a thorough audit of all medication cart; Result: No missing or unaccounted medications were found. Law Enforcement Involvement: On [DATE], officers from the [police department] entered the facility requested to speak with the Administrator regarding similar anonymous reports. The Administrator confirmed to officers that internal audit had been completed with no discrepancies. The police interviewed [MA A] on-site. Following the interview, law enforcement expressed no ongoing concerns and took no further action. Findings: No missing medications were identified. There is no evidence supporting the allegation of theft or diversion. The allegations appear to be malicious in nature, potentially made by an individual known to [MA A] from a previous place of employment. Conclusion: Based on the internal audit, staff interviews, and law enforcement input, there is no substantiated evidence of medication diversion or misconduct by [MA A]. No further investigation is warranted at this time. Corrective/Preventative Measures: continued routine medication carts audits will be performed. Staff reminded to immediately report any concerns of potential diversion. Documentation of this investigation will be retained in the Administrator's reference. The file did not include evidence of : interviews of staff, including MA A regarding the alleged drug diversion; documented medication audits; resident interviews, law enforcement notification; reassignment of MA A, state survey agency notification. Record review of the HHSC TULIP (system to which providers report accidents and incidents) on [DATE] revealed, multiple anonymous complaints were submitted that alleged MA A misappropriated multiple resident medications and items. The facility did not submit any Facility Reported Incidents regarding alleged misappropriation by MA A. Record review of Police Department Call Record Dated [DATE] revealed, on [DATE] at 03:26 PM the police department received an anonymous call regarding past theft at the facility. The complainant reported that they had observed MA A misappropriate medications at the facility. On [DATE] at 03:57 PM officers spoke to the Administrator at the facility and he notified them that the facility had received multiple calls that accused MA A of drug diversion but the Administrator did not believe the allegation because all the med counts had been accurate since MA A started working at the facility. Record review of an undated social media app chat conversation at 09:39 AM revealed, MA As status was active 1 h ago. MA A sent a 14 second video of her injecting Mounjaro (an injectable weight loss medication) into her lower left abdomen. In response the unknown individual responding, What are you doing pook MA A responded Mounjaro. I wanna get my own script but until I can afford the facility gone supply this shit , to which the unknown induvial responded Oh ok. Observation of an undated video and untimed video revealed, MA A injecting Mounjaro into her lower left abdomen in the facility central supply closet. A cabinet with a sign attached that read PLEASE DO NOT PUT OTC MEDS IN THIS CABINET FROM MED AIDE OR NURSES CARTS. PLACE ON CENTRAL SUPPLY. The rest of the texts could not be interpreted because the sheet was torn and folded. In interview on [DATE] at 09:35 AM, the Administrator said in December of 2024 the facility received multiple anonymous complaints that MA A

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. (continued on next page)

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	676165	A. Building B. Wing	11/24/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the daily staffing was posted and readily accessible for review for 1 of 1 facility reviewed for required postings. - The facility failed to update the facility nursing postings on 10/14/25 and 10/21/25. This failure could affect residents, facility visitors, vendors, and emergency personnel by placing them at risk of not having access to information regarding daily nursing staffing in a timely manner. Findings Include: Observations on Tuesday, 10/14/25, at 08:21 AM and 10:14 AM revealed, the facility Direct Care Report posting on the top of the nursing station facing the front door that read Monday [DATE]. The posting indicated that that the facility had a Day shift (6 AM and 6 PM) and Night Shift (6 PM- 6 AM) for LVNs, 3 Shifts (6AM- 2 PM, 2 PM - 10 PM, 10 PM- 6 AM) for CNAs, 2 shifts for CMAs (6 AM- 2 PM), 2 shifts for Restorative Aides (7:30 AM- 3:30 PM and 8 AM- 4 PM), 1 shift for RN Unit Mangers (8 AM - 4 PM) and 1 shift for RNs (6 PM- 6 AM). The posting indicated the facility census, number of staff types (RN, LVN, CNA, CMA and Restorative Aide) and total hours worked for all shifts. An observation on Tuesday. 10/21/25, at 09:57 AM revealed, the facility Direct Care Report posting on the top of the nursing station facing the front door that read Monday [DATE]. The posting indicated that that the facility had a Day shift (6 AM and 6 PM) and Night Shift (6 PM- 6 AM) for LVNs, 3 Shifts (6AM- 2 PM, 2 PM - 10 PM, 10 PM- 6 AM) for CNAs, 2 shifts for CMAs (6 AM- 2 PM), 2 shifts for Restorative Aides (7:30 AM- 3:30 PM and 8 AM- 4 PM), 1 shift for RN Unit Mangers (8 AM - 4 PM) and 1 shift for RNs (6 PM- 6 AM). The posting indicated the facility census, number of staff types (RN, LVN, CNA, CMA and Restorative Aide) and total hours worked for all shifts. In an interview on 10/22/25 at 10:17 AM, the Staffing Coordinator said her daily responsibilities included the daily schedule, managing the on call phone and the direct care report. She said she worked Monday through Friday from 08:00 AM to 05:00 PM and she put out the Direct Care Report daily in the morning when she came into work. The Staffing Coordinator said when she did not work on the weekend the Weekend Supervisor was responsible for it on the weekend. She said the Direct Care Report included the name of the facility, date, census type of staff, shifts and the total number of hours scheduled for the day. The Staffing Coordinator said she was not sure what time of the day the nursing posting had to be updated by but if the posting was not updated daily people would not know the staffing or coverage for the building for the day. She said she did not work on Monday 10/14/25 and Monday 10/21/25. She said when she returned from her day off she observed that the nursing posting was the same one she posted on Monday so it was not changed during her absence. The Staffing Coordinator said the DON and the Administrator were responsible for updating the posting when she did not work. In an interview on 10/22/25 at 01:34 PM, the Administrator said the staffing coordinator was responsible for updating the Direct Care Report, when she was absent, Talent or Learning staff made updates, but the DON and Administrator were ultimately responsible to update the staff posting. He said on 10/14/25 and 10/21/25 he was responsible for updating the Direct Care Report because both the Staffing Coordinator and Talent and Learning Staff were absent on those day and he failed to update the posting on those days because it was overlooked. The administrator said failure to update the posting daily could result in people not knowing the facility had adequate coverage and that residents were being taken care of to the best of their ability with appropriate staffing types. Record review of the facility policy Posting Direct Care Daily Staffing Numbers revised 07/2016 revealed, Policy Statement:Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementation: 1.The number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. 3. Shift staffing information shall be recorded on the Daily Nursing Hours Posting form for each shift. The information recorded on the form shall include: a. The name of the facility. b. The date for which the information is posted. c. The resident census at the beginning of the shift for which the information is posted. d. Twenty-four (24)-hour shift schedule operated by the facility. e. The shift for which the information is posted. f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift. g. The actual time worked during that shift for each category and type of nursing staff. h. Total number of licensed and non-licensed nursing staff working for the posted shift. 5. Within two (2) hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the Nursing Staff Directly Responsible

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	676165	A. Building B. Wing	11/24/2025

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Park Manor of Tomball	250 School Street Tomball, TX 77375

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident and ensure it had a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and that drug records were in order and an account of all controlled drugs was maintained and periodically reconciled for 1 of 10 staff (LVN A) for pharmacy services. - LVN A failed to maintain an accurate inventory of controlled substances when she failed to log into 80 controlled substances into the automated dispensing system on [DATE] which resulted in drug diversion. This failure could result in accurate controlled substance counts and drug diversion. Findings include: Record review of pharmacy delivery record dated [DATE] revealed, LVN A signed for a delivery of controlled substances that included: 1. 8 tablets of Acetaminophen/Codeine 300-30 mg (narcotic opioid pain medication).2. 8 tablets of Lacosamide 50 mg (anti-seizure medication).3. 16 tablets of Hydrocodone/Acetaminophen 5 mg-325 mg (narcotic opioid pain medication).4. 8 tablets of Clonazepam 0.5 mg (anxiety medication).5. 8 tablets of Hydrocodone/Acetaminophen 10 mg-325 mg (narcotic opioid pain medication) 6. 8 tablets of Lorazepam 0.5 mg (anxiety medication) 7. 8 tablets of Zolpidem 5 mg (sleeping medication).8. 8 tablets of Pregabalin 50 mg (anti-seizure and pain medication).9. 8 tablets Tramadol 50 mg (synthetic narcotic opioid pain medication). An observation on [DATE] at 09:45 AM revealed, the facility medication room had a keypad controlled access door. There was an automated dispensing system that required credentials to sign in. Record review of the facility provided undated investigation record revealed, 80 controlled substance tablets were missing which included:1. 8 tablets of Acetaminophen/Codeine 300-30 mg (narcotic opioid pain medication).2. 8 tablets of Lacosamide 50 mg (anti-seizure medication).3. 16 tablets of Hydrocodone/Acetaminophen 5 mg-325 mg (narcotic opioid pain medication).4. 8 tablets of Clonazepam 0.5 mg (anxiety medication).5. 8 tablets of Hydrocodone/Acetaminophen 10 mg-325 mg (narcotic opioid pain medication) 6. 8 tablets of Lorazepam 0.5 mg (anxiety medication) 7. 8 tablets of Zolpidem 5 mg (sleeping medication).8. 8 tablets of Pregabalin 50 mg (anti-seizure and pain medication).9. 8 tablets Tramadol 50 mg (synthetic narcotic opioid pain medication). On [DATE] LVN A signed for the 80 controlled substance tablets.On [DATE] the facility performed urine drug screens on only nurses and med aide on day shift and night shift. All staff tested negative except for 1 resident who had a valid prescription for stimulant medications. In an interview on [DATE] at 12:20 PM, RN A said on an unknown date in September an unknown nurse left medications unattended at the nursing station desk and someone stole it. She said the nurse was terminated after the incident. In an interview on [DATE] at 12:44 PM, LVN D said on an unknown date in September an unknown nurse left medications unattended at the nursing station desk and someone stole it. He said in response facility management drug tested all nurses and CMAs and the nurse that left the medication on the counter was terminated after the incident. In an interview on [DATE] at 01:17 PM, the Administrator said after the stolen controlled substances were delivered, they were not documented and then they went missing. The medications were never located, and the facility suspected they were stolen so they performed drug tests on staff. The Administrator said to his knowledge the medications were left on top of the automated dispensing system in the med room In an interview on [DATE] at 02:07 PM, the Regional Clinical Director said the diverted controlled substances were delivered to stock the automated dispensing system. He said after the incident, nursing staff checked common areas for the missing medications but they were never found. In an interview on [DATE] at 09:09 AM, LVN A said on Friday, [DATE], she received medications at the nursing station and when the pharmacy delivered medications they came in a big bag with multiple bags within them. She said when the medications arrived sometime between 7-8:00 PM she left the medications on the counter because at the time she had a resident who expired on her hall, so she was dealing with the death, the mortuary and the family of the expired resident. She said the medications remained unattended on the counter until approximately 4:00 AM towards the end of her shift when she cleaned up and put the big bag in the med room. LVN A said leaving medication on the counter was not out of the normal, everyone did that, and it just happened to be on her shift that someone decided to steal the medications. She said when she realized the controlled medications were missing on her next shift on [DATE] (Saturday), she immediately notified the Weekend Supervisor and they started looking for the medications in the med room, trash can and common areas. She said on the

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 10 staff (LVN A) reviewed for medication storage . - LVN A failed to ensure that controlled substances were stored behind a double lock when she left them unattended at the nursing station on [DATE] which resulted in 80 tabs of controlled medication stolen from the facility. This failure could place residents at risk of misappropriation of medications, adverse reactions to medications, overdose and hospitalization. Findings include: Record review of pharmacy delivery record dated [DATE] revealed, LVN A signed for a delivery of controlled substances that included: 1. 8 tablets of Acetaminophen/Codeine 300-30 mg (narcotic opioid pain medication).2. 8 tablets of Lacosamide 50 mg (anti-seizure medication).3. 16 tablets of Hydrocodone/Acetaminophen 5 mg-325 mg (narcotic opioid pain medication).4. 8 tablets of Clonazepam 0.5 mg (anxiety medication).5. 8 tablets of Hydrocodone/Acetaminophen 10 mg-325 mg (narcotic opioid pain medication) 6. 8 tablets of Lorazepam 0.5 mg (anxiety medication) 7. 8 tablets of Zolpidem 5 mg (sleeping medication).8. 8 tablets of Pregabalin 50 mg (anti-seizure and pain medication).9. 8 tablets Tramadol 50 mg (synthetic narcotic opioid pain medication). An observation on [DATE] at 09:45 AM revealed, the facility medication room to have a keypad controlled access door. There was an automated dispensing system that required credentials to sign in. Record review of the facility provided undated investigation record revealed, 80 controlled substance tablets were missing which included:1. 8 tablets of Acetaminophen/Codeine 300-30 mg (narcotic opioid pain medication).2. 8 tablets of Lacosamide 50 mg (anti-seizure medication).3. 16 tablets of Hydrocodone/Acetaminophen 5 mg-325 mg (narcotic opioid pain medication).4. 8 tablets of Clonazepam 0.5 mg (anxiety medication).5. 8 tablets of Hydrocodone/Acetaminophen 10 mg-325 mg (narcotic opioid pain medication) 6. 8 tablets of Lorazepam 0.5 mg (anxiety medication) 7. 8 tablets of Zolpidem 5 mg (sleeping medication).8. 8 tablets of Pregabalin 50 mg (anti-seizure and pain medication).9. 8 tablets Tramadol 50 mg (synthetic narcotic opioid pain medication).On [DATE] LVN A signed for the 80 controlled substance tablets.On [DATE] the facility performed urine drug screens on only nurses and med aide on day shift and night shift. All staff tested negative except for 1 resident who had a valid prescription for stimulant medications. In an interview on [DATE] at 12:20 PM, RN A said on an unknown date in September an unknown nurse left medications unattended at the nursing station desk and someone stole it. She said the nurse was terminated after the incident. In an interview on [DATE] at 12:44 PM, LVN D said on an unknown date in September an unknown nurse left medications unattended at the nursing station desk and someone stole it. He said in response facility management drug tested all nurses and CMAs and the nurse that left the medication on the counter was terminated after the incident. In an interview on [DATE] at 01:17 PM, the Administrator said after the stolen controlled substances were delivered, they were not documented and then they went missing. The medications were never located, and the facility suspected they were stolen so they performed drug tests on staff. The Administrator said to his knowledge the medications were left on top of the automated dispensing system in the med room. In an interview on [DATE] at 02:07 PM, the Regional Clinical Director said the diverted controlled substances were delivered to stock the automated dispensing system. He said after the incident, nursing staff checked common areas for the missing medications but they were never found. In an interview on [DATE] at 09:09 AM, LVN A said on Friday, [DATE], she received medications at the nursing station and when the pharmacy delivered medications they came in a big bag with multiple bags within them. She said when the medications arrived sometime between 7-8:00 PM she left the medications on the counter because at the time she had a resident who expired on her hall, so she was dealing with the death, the mortuary and the family of the expired resident. She said the medications remained unattended on the counter until approximately 4:00 AM towards the end of her shift when she cleaned up and put the big bag in the med room. LVN A said leaving medication on the counter was not out of the normal, everyone did that, and it just happened to be on her shift that someone decided to steal the medications. She said when she realized the controlled medications were missing on her next shift on [DATE] (Saturday), she immediately notified the Weekend Supervisor and they started looking for the medications in the med room, trash can and common areas. She said on the morning of [DATE] (Sunday) she called the Former DON, they searched the facility again and retraced her steps but the medications were