STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676194	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mason Creek Transitional Care of Katy	21727 Provincial Blvd Katy, TX 77450

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain clinical records in accordance with accepted professional standards and practices on each resident that are complete and accurately documented for 1 of 5 (CR#1) residents reviewed for clinical records. The facility failed to maintain a complete and accurately documented clinical record for CR#1. This failure could place residents at risk of not getting the care and services to improve their quality of life due to not maintaining complete and accurate clinical records.Record review of CR#1's face sheet dated 5/14/2026 revealed the resident was admitted to the facility on [DATE]. His diagnoses included disorders of kidney and ureter(impair urine production filtration or drainage), muscle spasm (involuntary contraction of the muscles), urinary tract infection (bacterial infection of the urinary system), severe sepsis with septic shock(a severe infection that triggers an extreme immune response where blood to vital organs is reduced), benign prostatic hyperplasia with urinary tract symptoms (a noncancerous enlargement of the prostate gland), and, malignant neoplasm of left kidney and hypothyroidism(a cancerous tumor originating in the left renal tissue). Record review of CR#1 quarterly MDS dated [DATE] revealed he had a BIMS Score 15 indicating he was cognitively aware. He was coded as having a catheter and was incontinent of bowel. Record review of CR #1's physician order dated 1/15/2026 revealed orders:1. Suprapubic catheter care every shift, monitor suprapubic insertion site for signs and symptoms of skin breakdown, pain, discomforts, unusual odor, urine characteristic or secretions and catheter pulling causing tension every shift day and night.2. Secure catheter with a leg strap/leg band or anchor to minimize catheter related injury and accidental removal or obstruction of urine outflow. Check placement every shift. Record review of the treatment administration record for CR#1, revealed there were blanks on the following dates: Day shift at 6:00am - 6:00pm4/1/2026, 4/2/2026, 4/7/2026, 4/8/2026, 4/9/2026, 4/10/2026, 4/11/2026, 4/12/2026, 4/15/2026, 4/16/2026, and 4/17/2026. Night shift at 6:00pm-6:00am 4/5/2026. Day shift 6:00am - 6:00pm4/1/2026, 4/2/2026, 4/7/2026, 4/8/2026, 4/9/2026, 4/10/2026, 4/11/2026, 4/12/2026, 4/15/2026, 4/16/2026, and 4/17/2026. Night shift 6:00pm - 6:00 am.4/5/2026. Record review of CR #1's physician order dated 4/25/2026 revealed Tizanidine HCL oral Tablet 2mg. Give one tablet by mouth two times a day for muscle spasm, rigidity and pain at 8:00am and 8:00pm. Record review of CR #1's physician order dated 1/15/2026 revealed an order for Tylenol Oral Tablet 325 mg (acetaminophen), Give two tablets by mouth every 6 hours as needed for pain. Record review of CR #1's MAR for April 2026 revealed no documentation that Tizanidine oral tablet 2 mg for muscle spasm and pain or Tylenol 325mg for pain to be given as needed. Record review of the MAR for April 2026 revealed the following:There was no documentation that PRN Tylenol was given on 4/25/2026 in the AM. The PRN Tylenol was last documented as given was on 4/24/2026 at 3:59pm by LVN T when CR#1's pain level was 7.There was no documentation that the one-time dose of Tizanidine 2mg was supposedly given on 4/25/2026 in the AM. Record review of nurse's notes dated 4/25/2026 at 5:20AM, written by RN A revealed documentation that Tylenol was not effective, however there was no documentation in the nurse's notes or the MAR that the medication was given. In an interview on 5/13/2026 at 12:05pm LVN T said (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she was the morning nurse who relieved the night nurse RN A. She said the night nurse told her CR#1 was in pain, and she gave him PRN Tylenol, and it was not effective and she called the NP and he told her to give CR#1 a one-time dose of Tizanidine and she should change the Tizanidine 2mg from once a day to Tizanidine 2mg twice a day for pain. In an interview on 5/13/2026 at 4:42pm with RN A she said CR#1 was groaning and she gave him PRN Tylenol, and it was not effective. She said she called the NP and informed him the Tylenol was not effective and he told her to give him a one-time dose of Tizanidine and then change the order to BID Tizanidine. She said she gave CR#1 the one-time dose of Tizanidine and the resident swallowed it and after he opened his mouth and she did not see any medication in his mouth. She said she documented the medication on the MAR and document in the nurse's notes. In an interview on 5/14/2026 at 9:20 am CR#1 said when he was at Facility J they did not change his suprapubic catheter once a month or clean his suprapubic catheter daily as ordered by his physician. He said regarding him not getting his medications on the day he was sent to the hospital he said he could not recall because he was in a coma. In an interview on 5/14/2026 at 11:13AM NP B said sometime after midnight on 4/25/26 RN A call to say CR#1 was in pain because he was groaning and she gave him Tylenol and it was not effective. He said he told her to give him a one-time dose of Tizanidine 2mg and then change the order to two times a day. In an interview on 5/14/2026 at 1:40pm RN C said there should be no blanks on the MAR. She said in nursing if it was not documented it was not done. She said the nurse should also document the PRN Tylenol and the one-time order of Tizanidine. She said they were going to in-service the staff on blanks on the MAR and documentation. In an interview on 5/14/2026 at 5:10pm with the DON she said there should be no blanks on the MAR. She said they should document on the MAR and nurse's notes if medication was given or the resident refused medication. She said staff will be in-serviced on documentation of orders. Record review of the facility's Policy and Procedures titled Documentation dated 7/2025 read in part.Subject: Charting and DocumentationDefinition of RecordThe resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms, and progress of the resident's condition. It is also necessary to include data needed for identification and communication with family and friends. Complete history of resident and present illness is required under the current law and regulations at the time of admission.Disciplines contributing to the record:1. Medicine2. NursingImportance and Use of The Record:1. To the resident it saves time if needed at a future date.2. To the institution it reflects the quality of care given to the resident.3. To the physician, it guides him in his treatment, use and effects of drugs and plan for care.6. To the nurse, it provides a multidisciplinary record of the physical and mental status of the resident.Rules for ChartingNotes are to be written on long-term residents as determined by the individual nursing service. Daily notes are required when the needs arises.