STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676208	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eagle Crest Rapid Recovery	9602 Huffmeister Rd Houston, TX 77095

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to immediately consult with the resident's physician and notify, consistent with his or her authority, the resident representative when there was a significant change for 1 of 3 residents (Resident #1) reviewed for notification of changes. The facility failed to notify MD of Resident #1 abuse allegation. This failure placed residents at risk for potential injuries, pain, and hospitalization. Findings included:Record review of Resident #1's face sheet dated 04/02/2026 reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included Alzheimer's disease (a progressive, irreversible neurodegenerative disorder and the most common cause of dementia), generalized anxiety (excessive, and uncontrollable worry about daily events) disorder, major depressive disorder (severe sadness, low energy, and loss of interest in activities (anhedonia) lasting at least two weeks), single episode, mild, dementia (brain disorders causing cognitive decline-memory loss, confusion, and behavioral changes that interfere with daily life), moderate, without behavioral disturbance (aggression, defiance, or impulsivity), and psychotic disturbance (loss of contact with reality, involving symptoms like hallucinations), and mood disturbance (persistent, and dysfunctional emotional states). Record review of Resident #1's Comprehensive MDS, dated [DATE], reflected the resident had a BIMS score of 02 that indicated the resident had severe impaired mental cognition. Record review of Resident #1's progress note dated 02/18/2026 at 10:40 a.m., reflected the resident had physical aggressive towards LVN A, hitting LVN A in face and pulling nurse's hair while assisting CNA A with transfer. The MD ordered Donepezil HCl (used to treat dementia associated with Alzheimer's disease by improving cognition) oral Tablet 10 mg give 1 tablet by mouth one time a day related to dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Created by LVN A. Record review of Resident #1's progress note/behavior note dated 02/18/2026 at 10:50 a.m., reflected a of Resident #1 refused all a.m. medications. While assisting resident with transfer, resident became physically aggressive hitting CNA A and LVN A in the face and pulling LVN A's hair while the staff attempted to transfer the resident from the bed to wheelchair. Staff redirection of resident's physical aggression was attempted but unsuccessful. Created By RN. Record review of Resident #1's progress note dated 02/23/2026 at 04:34 p.m., reflected resident received a skin/wound assessment by RN. The resident was content and approachable. RN found no evidence of any skin alteration or discoloration to arms, leg, face/head, back, hands or feet. RN to conduct further assessments when resident was transferred to bed. Record review of Resident #1's progress note dated 02/25/2026 at 12:38 a.m., reflected psychiatry NP evaluated Resident #1 for generalized anxiety disorder, other specified persistent mood disorders, dementia, severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and major depressive disorder, single episode, mild. Record review of Resident #1's audio/video recording on 04/02/2026 at 12:00 p.m., reflected, on 02/18/2026, CNA A said, You do not hit anyone in the face. Ugly, ugly, ugly, referring the resident's behavior of hitting the staff in the face. Audio recording noted Resident #1 screaming and then CNA A saying, You do not do that as to reference the (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident hitting staff. In an interview on 04/02/2026 at 11:05 a.m., with the ADM and the DON, the ADM stated on 02/18/2026 LVN A was asked by CNA A to assisted with Resident #1's bed to wheelchair transfer. The ADM stated after viewing an audio/video recording from a camera in the resident's room, he determined that after the transfer and LVN A leaving the room, CNA A said Ugly, ugly, ugly to the resident. The DON stated due to a past history of the resident being called ugly was a child, the resident found CNA A's ugly, ugly, ugly represented words hurtful. The DON stated she completed a face-to-face assessment on the resident after the incident and found no visual signs of bruises or abuse. The DON stated that reprimanding and chastising residents was explained unacceptable to CNA A and LVN A. The DON stated it was her expectation that when working with residents, staff would act gentle, patient, and explain to the residents what care was to be performed, giving residents time when residents become agitated. The DON stated CNA A was terminated as a result of the incident and LVN A resigned on 02/23/2026. In an interview on 04/02/2026 at 01:18 p.m., the RP stated Resident #1 had pain when moved due to metal in various locations of the resident's body. She stated on 02/18/2026, audio/video from the resident's camera captured CNA A calling the resident ugly. The RP stated when she came to visit the resident that same day, the resident was crying and saying, I am not ugly, and she had to tell the resident, no she was not ugly. The RP stated she placed signage on the resident's door informing staff to be careful when moving the resident. In an interview on 04/02/2026 at 03:47 p.m., the MD stated that it had been his expectation to avoid adverse effects from ANE Resident #1's abuse allegation should have been reported to him immediately for him to address immediately, The MD stated he was not aware of Resident #1's 02/18/2026 allegation of abuse. In an interview on 04/02/2026 at 03:58 p.m., CNA A stated on 02/20/2026, the ADM and the DON asked her provide a written statement of events that took place while providing Resident #1 patient care on 02/18/2026. She stated that the DON stated a report was received, where CNA A was overheard telling Resident #1 to shut up. She stated she explained to the ADM and the DON that on 02/18/2026, LVN A assisted her with providing incontinent care for Resident #1, and then later in the day, transferred the resident to bed, and then checked on the resident every 2-hours throughout the shift. She stated after the statement was written, she voluntarily resigned from her position with the facility. She stated the ADM and the DON requested she sign a resignation form, which she refused because she had not told the resident to shut up. In an interview on 04/02/2026 at 04:46 p.m., the NP stated Resident #1 had anxiety, memory issues, and issues with not wanting to eat. The NP stated the resident could become mean towards others when scared from not remembering what has happened in a day. NP stated on 02/23/2026, she assessed Resident #1 related to an abuse allegation made on 02/18/2026. The NP stated she was not aware that staff had commented to the resident her or her behavior was ugly or that the resident had issues with the use the word ugly from childhood. She stated it was her expectation to be informed of the specifics of abuse allegations and behavior issues to know how to specifically assess and treat the resident's behavior. In an interview on 04/02/2026 at 5:36 p.m., the ADM stated he was the facility's abuse coordinator. He stated CNA A and LVN A were suspended on 02/20/2026 after being made aware of Resident #1 abuse allegation. He stated his expectation was hat CNA A and LVN A followed ANE protocol. He stated after the investigation it was determined to terminate CNA A and LVN A resigned on 02/23/2026. He stated that the facility performed training in-services an ANE quarterly and more often as needed. He stated it was recommended that NP be made aware of Resident #1's behaviors for medication adjustment as needed. Record review of LVN A's two-week notice dated 02/18/2026, reflected LVN A ended her full-time employment to provide PRN effective 03/05/2026. Record review of training in-service dated 02/20/2026, reflected the DON provided an ANE training on residents are to be free from any form of abuse, and speak to residents with a respectfully, professional, and compassionate tone, and staff were to provide excellent customer service to residents and families. Suspected abuse, neglect, or exploitation should be immediately reported to the Abuse Coordinator, the ADM. CNA A and LVN A signed off acknowledging receipt of training. (continued on next page)

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Eagle Crest Rapid Recovery	9602 Huffmeister Rd Houston, TX 77095

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of disciplinary action form dated 02/20/2026, reflected CNA A's customer service offense relating to an allegation of inappropriate workplace conduct specifically alleged emotional abuse. CNA A was suspended pending investigation from a complaint reporting behavior described as demeaning, intimidating, and/or verbally harmful in nature. Record review of LVN A's incident statement dated 02/23/2026 reflected, on 02/18/2026, while LVN A assisted CNA A with Resident #1's bed to wheelchair transfer, the resident became physically combative. Resident#1 hit LVN A in the face three times and dug her nails into both LVN A and CNA A's arms during repositioning. The staff attempted multiple times to redirect Resident #1's aggressive behavior, unsuccessfully. No complaints of pain/discomfort voiced during transfer and resident transferred safely. LVN A exited the room leaving CNA A in the room with Resident #1. Record review of the facility's undated policy titled: Condition Change of the Resident (Observing, recording and reporting). Purpose: Observe, record and report any condition change to the physician so proper treatment can be implemented.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 1 of 7 residents (Resident #1) reviewed for abuse. The facility failed to ensure CNA A did not verbally and emotionally abuse Resident #1 when speaking rudely to Resident #1 on 02/24/2026. The facility failed to ensure Resident #1's resident's right to be treated with dignity and respect on 02/18/2026, when CNA A spoke rudely to Resident #1. This failure could place residents at risk of abuse, and mental anguish and fearfulness. The noncompliance was identified as past noncompliance (PNC) and began on 02/18/2024 and ended on 02/23/2026. The facility corrected the noncompliance before the investigation began on 04/02/2026 at 08:30 a.m. The findings were: Record review of Resident #1's face sheet dated 04/02/2026 reflected a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses which included Alzheimer's disease (a progressive, irreversible neurodegenerative disorder and the most common cause of dementia), atrial fibrillation (heart rhythm disorder causing rapid, irregular heartbeats (arrhythmia) due to disorganized electrical signals in the heart's upper chambers), transient cerebral ischemic attack (a temporary blockage of blood flow to the brain that causes stroke-like symptoms-such as sudden weakness, numbness, or confusion), generalized anxiety (excessive, and uncontrollable worry about daily events), disorder, major depressive disorder, single episode, mild, dementia (brain disorders causing cognitive decline-memory loss, confusion, and behavioral changes that interfere with daily life), moderate, without behavioral disturbance (aggression, defiance, or impulsivity), psychotic disturbance (a severe mental condition characterized by a loss of contact with reality), mood disturbance (persistent, and dysfunctional emotional states), pressure ulcer of right buttock (localized injury to skin and tissue caused by prolonged pressure), irritant contact dermatitis (chronic, skin inflammation causing itchy, dry, rash-prone skin) due to other agent, muscle wasting (loss of muscle tissue) and atrophy (muscle shrinking), difficulty walking, pain, muscle weakness, dysphagia (difficulty swallowing), and cognitive communication deficit (difficulty communicating, listening, speaking, reading and writing). Record review of Resident #1's Comprehensive MDS, dated [DATE], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 02 which indicated the resident had severe impaired mental cognition. Record review of Resident #1's progress note dated 02/18/2026 at 10:40 a.m., reflected MD ordered to administer Donepezil HCl (used to treat dementia associated with Alzheimer's disease by improving cognition) oral tablet 10 mg give 1 tablet by mouth one time a day related to unspecified dementia, moderate, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Resident physical aggressive with LVN A, hitting LVN A's face and pulling LVN A's hair while assisting CNA A with transfer. Record review of Resident #1's progress note dated 02/18/2026 at 10:50 a.m., reflected a behavior note of Resident #1 refusing all a.m. medications. While assisting resident with transfer, resident became physical aggressive hitting both CNA A and LVN A in the face and pulling LVN A's hair while being transferred from bed to wheelchair with redirection attempts being unsuccessful. Created By RN. Record review of Resident #1's progress note dated 02/23/2026 at 04:34 p.m., reflected a skin/wound assessment was conducted with resident in wheelchair as she was content and approachable at that time. No evidence of any skin alteration or discoloration to arms, leg, face/head, back, hands or feet. Further assessments to be conducted when resident when resident is in bed. Created by RN. Record review of Resident #1's progress note dated 02/25/2026 at 12:38 a.m., reflected an outpatient psychiatry evaluation for generalized anxiety disorder, other specified persistent mood disorders, dementia, severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and major depressive disorder, single episode, mild. Created by Psychiatry NP. Record review of audio/video on (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	04/02/2026 at 12:00 p.m., of a video recording dated 02/18/2026, reflected Resident #1's privacy curtain pulled obstructing the view of CNA A and LVN A providing the resident patient care. The audio captured reflected, CNA A saying, You do not hit anyone in the face then the words, Ugly, ugly, ugly, addressing the resident's hitting. The audio then recorded the resident screaming and then hearing CNA A saying, You do not do that, again referring to the resident hitting CNA A. In an interview on 04/02/2026 at 11:05 a.m., with the ADM and the DON, the ADM stated that on 02/20/2026 he received a complaint based on video footage captured on 02/18/2026, showing CNA A and LVN A transferring Resident #1 from wheelchair to bed. ADM stated Resident #1 required 2-persons assist with transfers. The ADM stated Resident #1 had a personal video/audio recording camera in her room. The DON stated Resident #1's bed was nearest the door and the recording device sat on a chest near the resident's bed. The DON stated once the staff completed the resident's transfer from wheelchair to bed, the video/audio captured LVN A leaving the room and CNA A left inside the room and audio captured CNA A saying Ugly, ugly, ugly to the resident. The DON stated the RP informed her that the words ugly, ugly, ugly, represented hurtful words for the resident because the resident had a past history of being called ugly as a child and caused an emotional reaction in the resident. The DON stated that regardless, no one should say that to any resident. The DON stated that the resident had metal implanted in various locations in her body resulting in pain during transfer. The DON stated that she completed a face-to-face assessment on Resident #1 after seeing the video and she did not find any visual signs of bruises or abuse and her wound care nurse completed the assessment notes in the resident's clinical record. The DON stated she spoke with both CNA A and LVN A and explained they could not reprimand or chastise residents. The DON stated it was her expectation that when working with residents, staff need to be gentle, patient, and explain what was about to happen to residents, and give residents time when residents become agitated. The DON stated that CNA A was terminated as a result of the incident and LVN A submitted her 2-week notice to end employment prior to the incident resulting in neither staff being employed with the facility any longer. In an interview on 04/02/2026 at 01:18 p.m., the RP stated she placed signage on Resident #1's door informing all staff to be careful when moving the resident, because the resident had lots of metal in her body and when moving her caused pain. The RP stated that she had placed a video recording camera in the resident's room just prior to this incident after the resident told her that that CNA A had told the resident to stop being difficult during a clothing change. She stated that incident was reported to the ADM and the DON. The RP stated that the resident had a diagnosis of Alzheimer's and was not being difficult. She stated in the morning of 02/18/2026 the audio video in the resident's room captured CNA A calling the resident's behavior ugly. She stated the words stayed in the resident's mind because when she came to visit the resident that same day, the resident was crying and saying, I am not ugly, and she had to tell the resident, You are not ugly,. She stated as a child the resident was called ugly and caused the resident to have body shaming image of herself throughout her life. She stated the word ugly caused the resident to become emotional. In an interview on 04/02/2026 at 03:47 p.m., MD stated he had not been contacted on or after 02/18/2026 regarding Resident #1's allegation of abuse. He stated that it had been his expectation that he would be contacted to address any adverse effects from the incident. In an interview on 04/02/2026 at 03:58 p.m., CNA A stated on 02/20/2026, the ADM and the DON asked her to write a statement explaining what occurred during patent care with Resident #1 on 02/18/2026, because the DON stated a report was received, that CNA A had told Resident #1 to shut up. She stated on 02/18/2026, she asked LVN A to assist with incontinent care for Resident #1, put the resident to bed, and then checked on the resident every 2-hours thereafter. She stated after writing the statement and speaking to the ADM and the DON, she voluntarily resigned. She stated the ADM and the DON asked her to sign resignation forms, but she refused to sign because she had not told the resident to shut up. In an interview on 04/02/2026 at 04:18 p.m., the DON stated that it was agreed that the facility would have a standard of care meeting with Resident #1's RP every Wednesday at 12:00 p.m., relating to difficulties with staff being unable to administer resident's (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	medications which could have been contributing to the resident's agitation and behaviors. In an interview on 04/02/2026 at 04:46 p.m., the NP stated she assessed Resident #1 on 02/23/2026 after an abuse allegation was made on 02/18/2026. The NP stated she had not been informed that staff had commented to the resident her or her behavior was ugly or that the resident had issues with the use of ugly from childhood. She stated she would address the resident's feelings in the coming visit. The NP stated that the residents had anxiety, memory issues, and issues wanting to eat. The NP stated that Resident #1 had behaviors of lashing out physically towards staff when feeling scared or having difficulties remembering people, places, and events thought out the day. She stated it was her expectation to be informed of the specifics of abuse allegations and behavior issues to know how to specifically address resident's behavior concerns. In an interview on 04/02/2026 at 5:36 p.m., the ADM stated that CNA A was suspended on 02/20/2026 and after an investigation determined to terminate CNA A. the ADM stated that LVN A was suspended on 02/23/2026 but resigned on the same day. He stated it had been his expectation that both staff were to follow protocol. He stated that the facility performed training in-services an ANE and resident rights quarterly and more often as needed. He stated it was recommended that NP be made aware of Resident #1's behaviors for medication adjustment as needed. He stated he was the facility's abuse coordinator. The following evidence was completed by the facility to correct the noncompliance prior to the investigation: Record review of LVN A's two-week notice dated 02/18/2026, reflected, LVN A would end her full-time employment to PRN effective 03/05/2026. Record review of training in-service dated 02/20/2026, reflected the DON provided an ANE training covering Residents are to be free from any form of Abuse. Speak to residents with a respectfully, professional, and compassionate tone. Staff are to provide excellent customer service to residents and families. Suspected abuse, neglect, or exploitation should be immediately reported to the Abuse Coordinator, ADM. CNA A and LVN A signed off acknowledging receipt of training. Record review of disciplinary action form dated 02/20/2026, reflected CNA A received a customer service offense after an allegation of inappropriate workplace conduct specifically alleged emotional abuse. A complaint was received reporting behavior described as demeaning, intimidating, and/or verbally harmful in nature. CNA A was suspended pending investigation. Record review of LVN A's incident statement dated 02/23/2026 reflected, on 02/18/2026, while assisting CNA A transfer Resident #1 from bed to wheelchair, the resident became physically combative, hitting LVN A in the face three times, and the resident used her nails to dig into both LVN A and CNA A's arms while attempting to reposition for the transfer. The resident was instructed not to hit staff. Multiple times to redirect resident's aggressive behavior, all redirection attempts were unsuccessful. Resident transferred safely, with no complaints of pain/discomfort voiced during transfer. After transfer LVN A exited the room leaving Resident #1 with CNA A. Record review of disciplinary action form dated 02/23/2026, reflected LVN A received a customer service offense after an allegation of inappropriate workplace conduct specifically alleged emotional abuse. A complaint was received reporting behavior described as demeaning, intimidating, and/or verbally harmful in nature. LVN A was suspended pending investigation. Record review of 7 of the facility's undated resident safe survey reflected 7 of 7 residents who were cared for by CNA A and LVN A felt safe within the facility, taken care of, and felt they were treated well. Record review of LVN A's background reflected the facility performed a criminal background check on 09/02/2025 finding no concerns for hiring. Record review of CNA A's background reflected the facility performed a criminal background check on 10/24/2025 finding no concerns for hiring. Record review of the facility's undated policy, titled: Abuse Prevention Program. Purpose: Protect the residents in this facility from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the residents, family members, legal guardians, surrogates, sponsors, friends, visitors or (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	any other individual. Record review of the facility's undated policy, titled: Policy: Resident Rights. Purpose: To ensure that resident rights are respected, protected, and promoted. To inform residents of their rights and provide an environment in which such rights can be exercised. Procedure: Residents do not leave their individual personalities or basic human rights behind when they move to a long-term care facility. This facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her quality of life and recognizes each resident's individuality and holistic preferences. This facility must provide a notice of rights and services to the resident prior to or upon admission and during the residents' stay. The information must be presented both orally and in writing in the language and in the manner the resident understands.